

PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

Strengthen Public Health Nursing for the Home Front

PUBLIC HEALTH NURSES! Our war work is to keep the home front hale and hearty. We are charged with the responsibility of helping to guard the health of the men and women whose toil makes it possible for a million of our own men to fight on the sea, on the land, and in the air, and for millions more to prepare for battle and for the defense of our own shores. All the old responsibilities of preserving family health are still ours. Mothers must be helped with bearing and rearing their children, and schools must be assisted with their health programs.

Our job has always been important. How well we have done it depends on how well we have used the resources at our command. Our pioneers in public health nursing had the vision to create the National Organization for Public Health Nursing as a resource for all concerned with community health—the nurse, the agency, and the public. Organized in 1912, year by year we have grown in usefulness as an instrument for public good. Membership is a badge of honor for individual and agency alike.

The N.O.P.H.N. has always relied on membership dues for a substantial part of its budget, but during these war years outside gifts have been drastically curtailed and the continuation of our fine service program depends squarely on the support received from individual and agency memberships. The job of every public health nurse is influenced by the N.O.P.H.N. in relation to salary

and working conditions, her very status under conditions of wartime distribution. Yet less than half of all public health nurses are individual members, and only a small part of agency board members.

The present membership of over 11,000 has been built up largely through the efforts of state and local membership representatives who have given generously of time and interest to press home the value of the N.O.P.H.N. membership to public health nurses and others concerned with community health. For the first time this year Lay State Representatives are being appointed in each state—especially to enlist other laymen. There is fertile ground to work on. Fourteen states only stand in the top third with 66⅔ to 100 percent of their number enrolled, 30 states are in the middle third, and 4 states are in the lowest third with less than 33⅓ percent enrolled.

For many reasons it should be easy to persuade public health nurses and board members to enroll in this of all years. The spirit of service is high. Public health nurses represent roughly only about 5 percent of the great pool of registered nurse power in this country. By very virtue of their small number each nurse assumes extra weight of importance to her community in relation to total nurse power. Membership in the National helps to ensure that each individual will give her most and best. Because of this grave responsibility there are many who will wel-

come this chance to help with the national budget. Many will want to increase their \$3 membership to the \$10 sustaining membership. For those who have \$100 to invest in a life membership, there can be no better time.

This year the N.O.P.H.N. needs you *and* your dollars in order to strengthen public health nursing for the home front.

EMILIE SARGENT, R.N., *Chairman*
NATIONAL MEMBERSHIP COMMITTEE

We Challenge Public Health Nurses

THIS ISSUE of PUBLIC HEALTH NURSING contains a group of articles dealing with the part played by the public health nurse in the great nationwide fight being waged against the venereal diseases. Social Hygiene Day on February 3, 1943 is just ahead of us as we go to press. This annual observance, sponsored by the American Social Hygiene Association, has come to be a day of reaffirmation of our determination that that fight shall be won. The nursing profession shares that determination and joins in that fight. It is most appropriate therefore that this issue should be largely devoted to a discussion of the function of the public health nurse in this complex undertaking.

The war against the serious but controllable diseases, syphilis and gonorrhea, is perhaps as ambitious a public health project as the nation has ever undertaken. Its success is vitally important to our wartime effort and our peacetime well-being. It is admittedly a huge task, demanding the close cooperation of the responsible professional groups and of the public itself. The need for early diagnosis, for treatment without interruption as long as necessary, for the careful tracing of contacts, all indicate the importance to an effective control program of those case-finding and case-holding techniques which are part of the professional equipment of the public health nurse.

The nurse is also, because of her close and friendly relationship to the individual patient and his family, in a strate-

gic position to make a major contribution to the control program by interpreting to the infected individual and his contacts the situation brought about by the fact of that infection. Most of us need help that is both efficient and scientific when we become seriously ill. When that illness is due to the spirochete or the gonococcus the threat of permanent damage and of loss of morale is a real danger. For many persons, fear, shame, attempted evasion of the unescapable, dominate the emotional picture. Here the nurse steps in to defeat the counsels of despair. These diseases can be treated, their ravages can be controlled; if treatment is administered early and continuously, they can be cured. Here is a message of hope for all. The public health nurse is the bearer of good tidings wherever she goes.

Miss Donna Pearce, in her article, "A Major Public Health Battlefront," speaking of wartime epidemiological problems and the potential contribution of the nurse to their solution says, "Will public health nursing meet this challenge?" I think that we can broaden this question to include the whole range of public health nursing activities in relation to the venereal disease control program and, having asked it, answer it with a hearty and confident "aye."

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Industrial Nursing Personnel Essential to Maximum War Effort

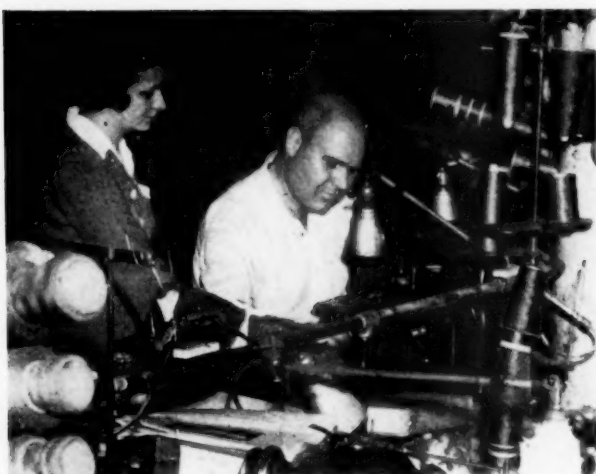
EXECUTIVE COMMITTEE, INDUSTRIAL NURSING SECTION OF
THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

MAINTEINING GOOD health and mental stability among industrial workers is fundamental to winning the war, and professional nurses are essential to effective health and safety programs. Adequate service to the armed forces is creating a shortage of nurses. In view of this shortage it becomes necessary for industry as well as hospitals and community health agencies to employ graduate nurses for functions that they alone can perform, and to delegate to trained helpers clerical details and first aid procedures which can be performed by them under supervision of a physician or a nurse.

The number of nurses necessary for a particular industry will be determined by the number of workers and the hazards of the industry. Two hours of nursing time a week for each unit of 100 employees is considered by the National Association of Manufacturers to be the minimum necessary to provide essential nursing service. Where workers are divided into two or three shifts the number of nurses per unit of workers on each shift, rather than the total, must be considered.

Large industries may supplement the work of graduate nurses by employing both men and women assistants for doing first aid in the central dispensary as well as in the first aid stations throughout the plant when such stations are maintained. These workers should be given both standard and advanced Red Cross first aid courses and such supplementary training by nurse or physician, or by both together, as may be indicated by the needs of the particular industry. They should be supervised regularly and frequently by a graduate nurse. A study should be made of the service being rendered in all first aid stations of large plants to determine where one nurse to an area might supervise assistants in carrying on work now being done by several nurses.

Responsibility of graduate nurses in industry falls most heavily upon the nurse in plants of from a few hundred to two or three thousand employees, where there is only a part-time physician or a physician on call, and where neither safety engineers nor welfare workers are employed. The current shortage of physicians is being felt particularly in these plants, and nursing activities are being increased here as elsewhere by the rapid labor turnover, employment of less physically fit workers, women and youths. In view of the general shortage of graduate nurses, women trained as nurse assistants and clerical helpers may be employed to help carry the increased



Henry Street Visiting Nurse Service

Professional nurses are essential to effective health and safety programs

load, working under supervision of the registered nurse or nurses already employed, rather than increasing the number of graduate nurses in these industries.

Small plants may combine to employ one nurse who serves part-time in each, or may purchase part-time nursing service from the local public health nursing agencies. These are plants that usually have little or no health service, but that greatly need it.

The Study of the Duties of Nurses in Industry, sponsored by the Public Health Nursing Section of the American Public Health Association, from which data were secured in 720 plants employing 2,370 nurses, provides a means for determining the scope of industrial nursing as it is being practiced today. The duties performed by the nurses in the industries included in the survey have been classified under eight major divisions, as shown in Column A of the accompanying table. Because the activities and responsibilities of industrial nurses vary according to the size of the plant and organization of the health service, the suggestions offered in the table for the conservation of the nurse's time are broken down into three categories, and listed in Columns B, C and D. Essential nursing services are indicated by N. Services for which the nurse assumes responsibility but which could be performed by auxiliary workers under her direction are indicated by N-Aux.

A ACTIVITIES IN WHICH INDUSTRIAL NURSES ENGAGE. As determined by data accumulated from 720 plants.	B Large plants with full-time physician, safety department, social service or welfare depart- ment.	C Smaller plants with part-time physician or physician on call, one or more full-time nurses, no safety engineer, no welfare department.	D Small plants with physician on call and using the divided service of one nurse or hourly V.N.A. service.
1. <i>Nursing treatment and care of occupational injuries and ill- ness; emergency treatment of nonoccupational illness.</i>			
1. Assisting physicians with care of injured and ill workers.	N-Aux.	N-Aux.	N-Aux.
2. Caring for workers who do not need attention of physi- cian.	N-Aux.	N-Aux.	N-Aux.
3. Referring workers with occu- pational illness or accidents to outside physician.	M.D.	N-Aux. (through M.D. on call)	Same as C
4. Referring workers suffering from nonoccupational illness to family physician.	M.D.	N	N
5. Training first aid assistants.	Authorized first aid instructors and N or M.D.	Same as B	Same as B
6. Supervising first aid workers.	M.D. or N	N	N
7. Maintaining adequate injury and illness records.	Clerical staff under M.D. or N super- vision.	N-Aux.	N-Aux.
II. <i>Assistance with the accident control and safety education program.</i>			
1. Interview injured worker and record information relative to accident.	N or clerk under supervision of M.D.	N-Aux.	N-Aux.
2. Instructing injured workers on safety practices at time treatments are given.	N-Aux.	N-Aux.	N-Aux.
3. Planning safety programs.	Safety department.	N in cooperation with foreman and other employees.	Same as C
4. Assisting with accident inves- tigation.	Safety department.	N in cooperation with foreman and other employees.	Same as C
5. Making recommendations for control measures.	Safety department.	N and safety com- mittee.	Same as C
6. Organizing safety committee and participation in its activ- ities.	Safety department.	N participates def- initely. May or may not organize.	Same as C
7. Issuing and maintaining per- sonal protective equipment.	Safety department.	N-Aux.	N-Aux.
8. Maintaining bulletin board.	Safety department.	N-Aux.	N-Aux.
9. Arranging safety education meetings.	Safety department.	N	N

A (Continued)	B (Continued)	C (Continued)	D (Continued)
10. Assisting with plant disaster activities.	Safety department.	N-Aux.	N-Aux.
III. <i>Maintenance of the plant medical department.</i>			
1. Ordering and arranging necessary supplies and equipment.	N-Aux.	N-Aux.	N-Aux.
2. Scheduling workers for examination and re-treatments.	Secretary	N-Aux.	N-Aux.
3. Completing and filing records.	Secretary	N-Aux. (except records of confidential nature)	Same as C
4. Representing the medical department in any interdepartmental planning and discussion.	M.D.	N in absence of M.D.	Same as C
5. Responsibility for integrating the medical services with other plant services.	M.D.	N	N
6. Analyzing or assisting with analysis of medical department records.	M.D. and N	N	N
7. Preparing medical department reports.	M.D. or N with clerical help.	N with clerical help	Same as C
IV. <i>Participation in the medical examination program.</i>			
1. Taking personal and occupational history.	N-Aux.	N-Aux.	N-Aux.
2. Explaining to worker value of examination and procedure to be followed.	N	N	N
3. Making vision and hearing acuity tests.	N-Aux.	N-Aux.	N-Aux.
4. Taking specimens for serological and other laboratory tests.	Technicians	N	N
5. Making blood pressure readings.	M.D. or N	N-Aux.	N-Aux.
6. Making X-ray plates.	Technician	Technician	Technician
7. Chaperoning women workers.	N-Aux.	N-Aux.	N-Aux.
8. Maintaining adequate health records.	N-Aux.	N-Aux.	N-Aux.
V. <i>Participation in the health education program.</i>			
1. Counseling with individual workers concerning personal health problems.	M.D. or N	N	N
2. Supplementing health instruction given by the physician.	N	N	N
3. Giving planned health supervision of workers with remediable or chronic conditions.	N	N	N

A (Continued)	B (Continued)	C (Continued)	D (Continued)
4. Teaching standard or advanced first aid classes.	To be delegated to authorized first aid instructors.	Same as B	Same as B
5. Posting health materials on bulletin board.	N-Aux.	N-Aux.	N-Aux.
6. Teaching nutrition.	Community nutritionist or N.	Same as B	Same as B
7. Writing articles on health for plant publication.	M.D.	N	N
8. Keeping sickness absentee records.	N-Aux. with clerical help.	Same as B	Same as B
<i>VI. Assisting with environmental sanitation.</i>			
1. Assisting with sanitary inspection of women's facilities.	N directing matron	N directing assistant	Same as C
2. Inspecting lunchroom.	N-Aux.	N-Aux.	N-Aux.
3. Selecting matron for women's facilities.	Personnel department	Personnel department.	Personnel department.
4. Training and supervising matrons.	Head matron.	N	N
5. Assisting with plant house-keeping.	Safety department.	N-Aux.	N-Aux.
<i>VII. Participation in plant welfare program.</i>			
1. Counseling with individual workers regarding personal social problems.	Social service department or welfare counselors.	N	N
2. Assisting with recreation program.	Not a nursing function. Personnel department.	Same as B	Same as B
3. Assisting with group sick benefit activities.	Personnel department.	N-Aux.	N-Aux.
4. Assisting with group hospitalization activities.	Personnel department.	N-Aux.	N-Aux.
<i>VIII. Services to ill or injured workers in their homes.</i>			
1. Home visiting to give nursing care and health supervision.	N. Delegated to local public health nursing agency where there is one.	Same as B	Same as B
2. Assisting workers with social problems in home.	Social service department cooperating with community agencies.	N cooperating with community agencies.	Same as C
3. Determining cause of absence.	Not a nursing function. Personnel department.	Same as B	Same as B

Note: Essential nursing services are indicated by N. Services for which nurse assumes responsibility but which could be performed by auxiliary workers under her direction are indicated by N-Aux.

Major Public Health Battlefront

By DONNA PEARCE, R.N.

"YOU KNOW you are really fortunate that Susie's sores led you to take her to the doctor and to find out that she is infected. Many people with syphilis do not get such warning signals and do not come in for treatment until the infection has made great headway and is much harder to cure."

Any public health nurse will recognize the considerations that underlie this diplomatic remark of a colleague interviewing a 16-year-old patient and her mother. Such a remark is a part of that diplomatic warfare against the venereal diseases which sometimes supplements and sometimes leads the scientific warfare.

This nurse is establishing herself first as the friendly professional ally of a family experiencing a social shock over the positive diagnosis of syphilis in their daughter. She then goes on to discuss the nature of syphilis, its way of spreading, and the means by which it is cured. She wins the patient to a sense of responsibility in following through with the medical plan, finds out the contacts, and brings them under treatment. In epidemiological terms, the nurse breaks a chain of infection.

The breaking of each chain of infection is particularly urgent in time of war when the nation must conserve its manpower for fighting and for producing the machines with which modern war is fought. A chain of infection running through a city where airplanes are made might easily reach into the factory and cause sick-time loss from work. A chain of infection in a mobilization area might reach into the Army camp and increase the days lost from training. The statement has been made again and again,

but because of its seriousness never becomes trite, that time lost through the venereal diseases in World War I was equivalent to a year's absence from duty of 19,000 men.

It is not only in communities called strategic that our efforts against the venereal diseases are vital to our fight to win the war. Syphilis and gonorrhea are just as mobile as the people who carry them. In this era of rapid movement of populations, an infection from some remote village may spread in short order halfway across the continent to some town that is a pivot in our war production.

PREVALENCE OF INFECTION

We have plenty of evidence as to the hold that the venereal diseases have on the people of the United States. The rates of infection among the first million men examined under Selective Service shocked the whole nation in the spring of 1941 and set all the editorial writers reaching for their pencils. Preliminary analysis of the results from succeeding examinations shows much the same serious rates.

A study has recently been published by the National Youth Administration and the United States Public Health Service on the results of physical examinations made of NYA youth to determine their eligibility for employment on the work projects of that organization. About 17 per 1,000 youth were recommended for treatment for some venereal disease. One challenging fact in this study is that venereal disease in a communicable stage was responsible for the classification of many of these youth as temporarily unfit for work.

As to the venereal diseases among the

SYPHILIS AMONG TWO MILLION SELECTEES IN THE UNITED STATES



—Based on serologic tests of selectees, aged 21-35, reported between November 1940 and August 1941, corrected for age, race, and residence within each state. Data incomplete for Idaho, Kentucky, Oregon, and Vermont. Figures from U. S. Public Health Service.

general population of this country, conservative estimates put the number of people infected with syphilis around 3,200,000. Gonorrhea, we know, outranks syphilis in rate of attack and may be compared in point of incidence to measles or the common cold.

CONTROL A MUST

The control of the venereal diseases is a must in the public health fight to win this war. The public health nurse as a professional person and as a citizen is bound to consider this in weighing her responsibilities at this time. She has a large responsibility in the national fight on these diseases, and this is bound to pull down the side of the scales marked "Essential Duty on the Home Front." The public health nurse, by virtue of her particular skills for a particular battle-front, is not wholly free to say, "I'd like to get into action where the war is going on." For her, the better part of duty and of valor may frequently lie in her recognition that she must fight on the home front.

At the very time that the need for

professional workers in venereal disease control is increasing, the number of medical personnel available to the civilian population is growing steadily less. As the shortage of physicians in civilian communities becomes acute, nurses will be called upon to perform under medical supervision more of the duties and functions normally carried out by the doctor. Then, too, the demand for actual nursing care will mount with the development of artificial fever therapy and other rapid treatment schedules for the cure of syphilis.

ECONOMICAL USE OF NURSES

As depleted staffs try to keep up with increasing duties, many activities formerly performed by nurses will have to be delegated to nonprofessional workers. Many clinics have risen to the demand for flexibility and readjustment. Changes and modifications already in effect in many places include:

1. The release of the public health nurse from many clerical and house-keeping duties through the use of volunteer or paid clinic assistants.



The public health nurse is needed in the campaign against the venereal diseases

2. The employment of inactive nurses (often local married women) as clinic nurses on a part- or full-time basis to assist with treatment procedures or to administer drugs under the supervision of a physician.

3. The assignment of a minimum of public health nurses or medical social workers in clinics:

- a. To interview newly-diagnosed patients, patients who become pregnant, patients who are reinstated to treatment, others who request or need reinstruction, and those referred by clinic physicians;
- b. To select for field visits (under direction of a physician) those lapsed patients in most urgent need of treatment; contacts as indicated by time and type of exposure; and to allocate these visits to appropriate personnel. In accordance with the recommendation of the State and Territorial Health Officers' Conference in March, 1942, lay follow-up workers are being employed to make visits to selected patients and contacts. Male investigators are proving their value, particularly in visiting infected selectees, in locating contacts in "juke joints" and taverns, and in obtaining information about contacts from soldiers on army posts;
- c. To make those visits which are too urgent

or too complicated to allocate to lay workers, as well as the visits to families already under supervision for other reasons;

- d. To be responsible (where physicians are not available) for other follow-through activities that are considered a *sine qua non* in today's work of control, such as clearance with central registries and private physicians, correspondence, referrals, transfers, travel records, and similar work.

4. Increasing the emphasis on special consultative and educational services. Twenty state health departments now have at least one advisory nurse with special preparation in venereal disease control. Many urban organizations have local supervisors with similar training. Such assistance is even more necessary at this time when many new nurses and lay workers must receive their training on the job. Moreover, bridging the gap in the education of the public health nurse with reference to the venereal diseases is of vital importance if her contribution is to be effective.

Public health nursing was not prepared to cope with the venereal diseases in the last World War. November 6, 1919 marked venereal disease history for our profession. On that date 16 public health nurses finished a four-months' special training in venereal disease control arranged cooperatively by Columbia University, Bellevue Hospital, the New York School of Social Work, and the U. S. Public Health Service. Scholarships for 15 of these nurses were provided by the American Red Cross. This was the first group of nurses specially trained for such work in the United States.

At their graduation exercises various speakers laid stress on the importance of the nurse in venereal disease control. Doctor C. C. Pierce, then Chief of the Division of Venereal Diseases of the U. S. Public Health Service, expressed the hope that every university concerned with the preparation of public health nurses would in time offer similar courses. This was a noble start; but

*U. S. Public Health Service*

The nurse greets patients at the trailer-clinic in rural Georgia

unfortunately congressional appropriations for venereal disease control sharply decreased, the first momentum in the campaign fell, and interest in venereal disease education likewise waned. It was found that public health nursing preparation in venereal disease control at the beginning of the revived federal campaign in 1935 had not advanced to any significant degree.

SPECIAL NURSING PREPARATION

Something has been done, however, within the past five years to take up this slack. Four of the universities offering courses in applied epidemiology of the venereal diseases have reported to date a total of 194 public health nurses completing such courses. In addition, 106 public health nurses have been enrolled in summer institutes and special classes in venereal disease control offered by these same universities. Special institutes and classes have been offered also in other universities from which we do not have reports. Some may say that even this is "too little—too late" for the present crisis. However, the splendid work being done by many of these public

health nurses indicates that they may be the leavening factor in the rise of public health nursing to meet the increasing demands.

The public health nurse's work in the control of the venereal diseases has never been so clearly focussed as her work in other communicable disease fields. When typhoid fever, diphtheria, or scarlet fever stage epidemics, there is no question about giving precedence to whatever epidemiologic procedures are required by the outbreak. Syphilis and gonorrhea tend to spread in small epidemics and are constantly among us. Is this the reason that the same recognition has not always been given these diseases nor provision always made for epidemiologic services within the framework of the generalized program? The application of the principle of control through treatment necessarily brought nursing assistance into the treatment picture, but too often there has been little thought or plan for the epidemiologic aspects beyond those connected with family problems. Is it because the nurse has concentrated upon the family as the unit of service that she has been slow in grasping the concept

of syphilis, gonorrhea, and chancroid as infectious diseases which are for the most part extra-familial in nature?

ROOTS OF INFECTION

In war time, prostitution furnishes a problem group of contacts. Past evidence shows that 75 percent of venereal disease infections among the armed forces are spread by prostitutes or by girls away from their home surroundings. When the army marches, the "camp followers" are not far behind. The "sea gulls"—transients commonly using fictitious names—follow the ships from port to port. The "bar flies" are self-constituted hostesses to welcome the soldier, sailor, or war worker who has dropped in for a drink. The "B" girls solicit their clients while they work as waitresses in taverns. These girls usually live in trailers, cheap rooming houses, or second rate hotels. Or they may operate as transients, coming into town by way of taxi or automobile to ply their trade overnight and be off in the morning. Time is of the essence when these girls are named as sexual contacts. Hours count in the control of infectious syphilis or acute gonorrhea.

DOES PUBLIC HEALTH NURSING FAIL?

The lack of integration and acceleration in handling the extra-familial aspects of the problem within the generalized public health nursing service has led some venereal disease control officers to believe that only the specialized approach can be successful. Will public health nursing meet this challenge? Will medical and nursing leaders plan together so to align the work of venereal disease control with other public health activities that every public health nurse will have a share in the fight, and that any specialized assignments will be supplemental to and not a substitute for the work of the generalized nurse?

Public health nursing can take courage for the problems to be met and the readjustments to be made, from the progress

of the national program of which it is a part. In the last five years of peace this country prepared itself to fight these diseases which become such devastating saboteurs in time of war. Funds for a national venereal disease program have been available since 1935 under the Social Security Act and since 1938 under the Federal Venereal Disease Control Act. A good basic structure for control has been built up by the power of these funds in the hands of venereal disease experts, and through the untiring efforts of interested individuals and agencies.

GROWTH OF SERVICES

Today every state and every city with a population over 500,000 has a section for venereal disease control under the direction of a full-time officer. Today this country can count more than 3,300 clinics for treatment of these diseases, or 300 percent more than the number in 1938 when the Federal Venereal Disease Control Act was passed.

More revealing in a personal sense than the increase in sections and in clinics is the increase in services to infected persons. In 1942 the total number of blood tests reported was 17,400,000, or 480 percent more than the number reported in 1938. Nearly 10,600,000 syphilis treatments were given in public clinics in the fiscal year 1942, an increase of nearly 260 percent over the number given in 1938.

Services to infected persons have improved not only in quantity but also in quality. During the past six years the Committee for the Evaluation of Serodiagnostic Tests for Syphilis has surveyed annually the results of the techniques used by various state laboratories. The condition under which state laboratories share in federal grants is that their work be up to a set standard. Each annual appraisal has revealed improvement in their services. The 1941 survey showed that nearly all state laboratories perform satisfactory serologic tests for syphilis.

The increase in services to infected persons has been helped along by the free distribution of drugs in every state to clinics and private physicians. The success of the sulfonamide compounds in the therapy of gonorrhea has been followed up by mass-scale distribution of these drugs. Today, the outstanding drug for the treatment of gonorrhea is sulfathiazole which by its performance promises rapid progress in the control of this disease.

The possibilities for curing syphilis in a shorter space of time have grown better as the massive dose method of anti-syphilitic therapy has been studied and tested in the past several years. The utilization of artificial fever-therapy as an adjunct to chemotherapy in the treatment of early syphilis is being studied. These methods for the present are still considered experimental. We can hope, however, with a great deal of certainty that eventually the time, effort, and expense required for the eradication of early syphilis will be greatly reduced.

MORE LAWS

State legislatures have contributed legislation against the progress of the venereal diseases. In 1935 one state had legislation requiring a blood test before marriage; today 26 states have premarital legislation to guard against the transmission of the venereal diseases through marriage. Twenty-six states require that a serological test for syphilis be included as a part of the examination of pregnant women.

SOCIAL PROTECTION ASPECTS

The war turned the venereal disease attack into a threat on our national safety, and made necessary the repression of prostitution. The May Act, which became a law in July, 1941, makes prostitution illegal within such reasonable distance of military and naval establishments as the Secretaries of War and Navy shall determine to be needful to

the efficiency, health, and welfare of men in the military services.

The Section of Social Protection within the Federal Security Agency works with local police authorities in areas around army camps, naval stations, and defense industries to bring about legal repression of prostitution. The efforts of this section go beyond repression and are directed to social control by urging recreation, vocational training, and opportunities for constructive work among migratory girls and women.

The American Social Hygiene Association has gone forward with its eight-point program on 48 state fronts. This Association has reported on field studies of prostitution which have been made in 176 communities since a state of emergency was declared.

The nation is geared to a venereal disease control program that should check the sabotage which these diseases carry on in time of emergency. The Congress appropriated 12½ million dollars for venereal disease control for the fiscal year beginning July 1, 1942. This is a wartime appropriation, and it must be made to do a wartime task. We should reach all the selectees rejected because of venereal infection instead of the approximately 50 percent so far being reached according to present estimates. We should find and treat a far greater proportion of infected war workers. We should consider as a special challenge the fact that in 1940 only one in eleven pregnant women with syphilis received the minimum amount of treatment necessary to prevent infection in the child—34,000 syphilitic babies were born alive that year. We must find and treat thousands more of those infected in the general population. And everlastingly we must search out the contacts.

Since 1935 our nation has been putting up an ever stronger counter-effort against these diseases that have flourished for centuries. But we cannot permit ourselves today to be satisfied

with a good fight against them. We cannot be satisfied with a good war against the dictators; we have to wage a total war against them, a victorious

war. Likewise, we must work for nothing less than victory over the venereal diseases, for our national safety now and for our collective health for all time.

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Extra-Familial Contact Tracing

By MARY A. BURKE, R.N.

CASE FINDING in syphilis and gonorrhea is war work. In spite of depleted staffs, present case finding methods must be improved because these two diseases destroy the manpower of our country. All public health nurses who remain in service on the home front must be charged with the burden of contact tracing in this field. To do this, there must first be a very careful analysis in every community of the present public health nursing program, in order that the limited nursing service available can be distributed to secure its maximum value.

Throughout the years, doctors, social workers, male investigators, and specialized nurses have carried on the greater part of the program of extra-familial contact tracing in gonorrhea and syphilis. Their persistent work has brought case finding in this field to its present degree of efficiency. Today, many planned programs throughout the country are being upset, as medical men who worked as epidemiologists are taking their places on the far-flung fronts of this global war, as male investigators are answering the call to the armed forces or to war industries, and as 3,000 American nurses each month are being called to military service.

In the light of the grave problem which gonorrhea and syphilis present as saboteurs of the national war effort, every public health nurse should spend a part of her time each day on gonorrhea and syphilis case finding. Specialized nursing service in this field needs to be replaced by generalized service if the maximum amount of efficiency is to be obtained. The public health nurse in uniform doing family work, whether she is in the field, the clinic, or in the indus-

trial plant, can contribute immeasurably to extra-familial contact tracing. Tangible results will be seen in terms of a higher case finding ratio.

Because these two diseases affect the health of millions of persons in the United States, the problem can never be adequately handled even by hundreds of nurse specialists doing gonorrhea and syphilis work. Twenty-three thousand public health nurses making over 29,000,000 family visits each year, devoting part of their time each day, are needed to reach these millions if progress is to be made.

CAN THE GENERALIZED NURSE DO IT?

There are many reasons why some health officers will not subscribe wholeheartedly to such a plan. Some believe that it is impossible for a public health nurse to perform equally well in all branches of nursing. They compare the nursing field to the medical field. They will say, "When you need surgery, get a surgeon. When there is a baby to deliver get an obstetrician." "You don't go to a syphilologist when you have tonsillitis," says one. That might be an advantage if what the patient describes as tonsillitis happens to be evidence of secondary syphilis. We will agree that specialists are needed in the medical field because of the intricate details of diagnosis and treatment, but nurses do not have such responsibilities and, moreover, few if any diseases can be treated successfully out of relationship with other members of the family group or the family situation. We must remember too that there is always a family situation. The single man or woman living in a rooming house is a part of some family group.

The health officer who thinks in terms of the nurse specialist compares her field to the same field in medicine. They are not analogous in this respect. The doctor needs to know infinitely more about surgery, syphilology, and other specialties than the nurse needs to know to give expert nursing care in these very same fields. The unlimited knowledge that a doctor must have to do his work well in each field makes it easy for us to understand why it is possible for him to believe that the nurse specialist is more capable of carrying out the syphilis and gonorrhea program than the generalized nurse.

The essentials desirable for all public health nursing work are needed for gonorrhea and syphilis work also. These include, in addition to the basic course in an accredited school of nursing, at least the content of a year's postgraduate study in public health nursing, and practical public health experience under supervision. The public health nurse needs special training in the control of communicable diseases, in recognition of social problems, in the study of human behavior to learn what makes people feel and act the way they do and what kind of reasoning will win them, in educational techniques for teaching health, and in basic techniques of guidance. She must possess sympathy, tact, friendliness, an ability to understand patients and their problems, a genuine interest in the program and an ability to talk to patients and to interpret doctors' instructions in a language that patients understand. These essentials are necessary to a public health nurse's success, whether she is giving nursing care to a patient with scarlet fever, a prenatal patient, or an extra-familial contact to a gonorrheal, tuberculous, or syphilitic patient.

In addition, in order to work in the field of gonorrhea and syphilis, she needs to have a thorough knowledge of these diseases—not the same as the physician possesses, but enough to interpret intelli-

gently his orders in this field just as she would do also in the field of tuberculosis. Generalized nurses will never become proficient in the field of gonorrhea and syphilis until they do the actual work. Only a part of this work can be learned from listening to an eminent lecturer in the field, attending classes, reading the books written by specialists and observing the specialist in action. To complete the nurse's experience, she must see how patients in this field react to what she has said to them. We all learn by doing. Staff education programs which permit nurses to observe the work well done, to participate in the work, and then to demonstrate to the supervisor, will offset any notion that generalized nurses cannot give service in this field as well as in other fields.

WHAT ARE PERSONAL QUALIFICATIONS?

The second objection is often stated as follows: "Not every nurse in the program can be trusted to do this highly important job—only the 'top-notchers' will ever be permitted to participate." It is well for us to remember that the world's work is done by average persons. Many average nurses ever conscious of the program to control gonorrhea and syphilis can do more work and produce better results than can a few very superior nurses. A nurse in a large clinic, who might easily be thought of as only average, sold more patients "spinals" in one month than did three other nurses who are considered to be unusually well informed. Observation disclosed that besides the information which she imparted, equally important were her sympathy and genuine interest in what concerned her patients. We need to keep in mind that "top-notchers" have no corner on sympathetic understanding, on sincere interest in the welfare of others, or on obtaining cooperation.

There may be some nurses on generalized nursing staffs whose basic train-

ing lacked experience in syphilis and gonorrhea. A few of these nurses may not feel emotionally able to prepare themselves for this work. These nurses only should be excluded from the program. Every public health nurse who wants to participate should be permitted to do so. It is safe to assume that the nurse who is interested will get the information she needs to do the work well.

GENERALIZED NURSE HAS ASSETS

There are some doctors and nurses who believe that even the well-trained nurse specialist may not participate in all phases of the program. This is often their attitude toward follow-up visits to single persons living at home or in a rooming house. It is often felt that all these patients want to conceal the fact that they are infected and that a visit by the specialized nurse would jeopardize this secret. The public health nurse's training especially prepares her to handle such delicate situations with tact. Because she is doing generalized nursing work in the district, there would be any one of a number of reasons for her being in such a place.

In observing a number of calls on single persons by generalized nurses in a certain area, it was found that the nurses often carried family records on members of the household. This observation also revealed that most single persons do not hesitate to tell members of the family about the infection. The mother, aunt, or landlady was often aware that the person attended the clinic and in most instances knew why treatment was needed. We are inclined to believe that all patients react to situations the way we ourselves would react in similar circumstances. Not all persons are ashamed and upset when they learn they have syphilis or gonorrhea. One nurse in a generalized program asked a patient who is single and living in a rooming house why she did not

report to the tuberculosis clinic for an X-ray. She said, "I can't nurse, I go to the 'Sosh Hi' on Friday for gonorrhea." On her refer card was entered the designation "Soc. Hy." for social hygiene clinic. This patient who was a post-sanatorium tuberculous case reported to the nurse that she attended the social hygiene clinic with the same affection one would boast of a coveted membership in a sorority! At the same time, because she was a single woman living in a rooming house, the district generalized nurse had not been routinely informed that she was infected.

All of you recall the article and picture in one of the weekly magazines a few years ago about a mobile medical unit in Alabama. A number of infected persons were discussing the results of the Kahn test. One of them with a strongly positive result said, "Make way for a four-plus man." The nurse who works in a generalized program understands well the difference in attitude of all the infected persons and their contacts. She takes these facts into consideration when she plans her family work.

IS CONTACT TRACING SAFE?

Some other doctors and nurses believe that it is not safe to permit nurses to follow gonorrhea and syphilis contacts into rooming houses, cheap hotels, and brothels. They do not, however, fear for her safety as she goes into the same houses on case finding expeditions in tuberculosis and other communicable disease fields. Public health nurses in a generalized program are expected to do all other kinds of nursing service in these same situations. A single man or woman residing in a rooming house or a cheap hotel who is a contact to tuberculosis is visited by the generalized nurse. If the same man or woman is a contact to gonorrhea or syphilis, he or she is often deprived of the special service which the generalized public health nurse is prepared to give. Persons without a

medical background are sometimes chosen to do this work because of their special ability to force a door or because they may assume the disguise of a prospective customer and in so doing succeed in bringing the alleged contact in for examination. The persuasive methods of the generalized public health nurse will take precedence over an application of force or any undercover methods.

With regard to her safety, the poise and uniform of the public health nurse is sufficient to protect her. In the slums of a certain city where police officers patrol their beats two by two in daylight, public health nurses in uniform go alone. The uniformed nurse is welcomed where other persons are looked upon with suspicion and often denied admission.

SERVICE FOR ALL IS A RIGHT

Each individual in the community has just as much right to the services that generalized nurses are prepared to give as have the elite on the avenue or the mothers in a tenement. A woman who "works" in "Hattie's Place" who is given as an extra-familial contact to a case of gonorrhea or syphilis needs the health message that the nurse can bring. Experience has shown that she will listen to it. The prostitute's child who lives "across the tracks" needs to be protected against smallpox and diphtheria as all other children in the community. When a generalized public health nurse is permitted to make such a call she will do many things in addition to referring the woman for the specific examination. She will discuss the importance of a chest X-ray, the value of normal nutrition, and other matters vital to good health. Also, as a result of the nurse's visit the madam can be taught to place a different value on untruthful negative health reports.

Dr. Parran tells us statistical studies reveal that at least three persons are exposed to syphilis or gonorrheal infec-

tion for every one that comes for treatment. He says it is usually true that two of these persons need treatment. In order to approach this tremendous problem of case finding generalized nurses must not only follow cases found in clinics but they should assist the private physician in follow-up work. Generalized nurses should, we believe, receive the reports of every case of early syphilis and gonorrhea that is found in their districts just as they receive the reports of cases of scarlet fever and tuberculosis. Many physicians who in the past have been able to do their own case finding will now find it impossible to carry this burden and will welcome help from the generalized nurse. It is thought by some that public health nurses are not welcome in private physicians' offices. Public health nurses doing family work are greeted with cordiality when they enter the offices of private physicians who use their services in tuberculosis, child welfare, prenatal and in other fields. The private physicians will not be less friendly to nurses when they take on this important case finding work.

WHERE ARE THEY HELPING?

In one city a uniformed nurse specialist has successfully assisted doctors in a certain area by participating in a case holding program. Recently another nurse specialist has begun to do case finding work upon requests from private physicians and hospitals. In another large city nurses keep detailed records of every case of early syphilis in the office of a private physician or a hospital clinic. These cases are all followed until a minimum of 20 doses each of an arsenical and bismuth have been received. The doctors give this information to the nurses willingly. They also invite them to make home calls on delinquent cases. In the same city doctors make appointments for nurses to interview early cases of syphilis in their offices in an effort to have more contacts examined. These

specialized nurses give evidence of successful work readily acknowledged by their medical associates. We believe that generalized nurses with proper preparation and supervision can be brought to a like state of efficient service. Doctors throughout the country who are concerned with the welfare of the people of the community will be glad to have the help of uniformed generalized nurses. In return, they will give her the fine loyalty and cooperation which she gives to them. Both the doctor and the nurse need this kind of cooperation to fortify their positions in the business of protecting community health. Physicians will discover that in this field as in all the others the generalized public health nurses are a valuable adjunct to their service.

WHAT PREPARATION IS NEEDED?

The success of the public health nurses in this undertaking will be in proportion to the preparation given to them in the field. To initiate such a plan successfully small areas at a time could be taken into the program. Here generalized nurses should be given the responsibility for all the case finding and case holding work. The emphasis should be placed almost entirely on gonorrhea and early syphilis. A review of recent literature reveals that many health officers believe that little time should be spent in this war emergency on late syphilis patients, either in the clinic or in the field. The policies and routines having been prescribed by the director of the service, participants in the program should then receive uniform instruction from the nursing administrator. This will save the time of the busy health officer and his assistants. Dr. C.-E. A. Winslow says "The morale of a staff is always highest when under the direction of a professional colleague."

Provision needs to be made for a continuous staff education program. Information tests on all phases of the work

should be available for the nurse entering such a service. She and the supervisor will then know on what level she must start. Review tests should be supplied at short intervals. Actual calls should be presented in conference. Demonstrations in the field should be given. Some time should be devoted to an exchange of experience and ideas. The value of using different agencies and individuals in her district to assist her effectively in her work should be stressed. Even the druggist is important to her work. When he knows that the generalized nurse also is participating in this program there is reason to believe that he will refer to her patients with symptoms of gonorrhea and syphilis, just as he now refers the mother with a sick baby.

SPEED IN GETTING FACTS IS NEEDED

The clerical system should provide facilities for obtaining quickly information for field nurses and for clinics and private physicians. Case records should be filed in family units so that decisions made in the clinic with regard to a patient will be made in relationship to the family unit. There is distinct advantage in having all records at one address in one unit. This is especially true when the clinic is planning a program of treatment for mothers and their children. In a certain clinic, one woman said she did not return with her baby who had early congenital syphilis because the doctor had told her to visit another medical department before she came back. The baby's record was not with the mother's and the mother assumed that both of them should return at the same time. In small clinics such a situation would not be a problem but when case loads reach six figures there are tremendous complications. Also it is apparently difficult to convert large individual numbering systems once started to family systems under the present methods of central tabulation.

Nurses should be urged to keep records

of their achievements in the field of gonorrhea and syphilis as they do in the others. In this way they will be stimulated by their own results and the collective efforts of the group.

A huge fire of infection is raging in all parts of our country. This blaze, constantly fanned as the gonococcus and the spirochete fall on fresh fields, cannot be extinguished by sporadic efforts in case finding. Thousands of persons are needed to subdue the conflagration.

EVERY NURSE HAS RESPONSIBILITY

Every public health nurse in this country should participate in the control of gonorrhea and syphilis. There are thousands of nurses in war plants who could do effective extra-familial contact finding if they were under centralized direction. Their service would be of enormous advantage in these days when the private physician has scant time even to give needed treatment. The nurse could instruct the patient in matters regarding his infection and secure information about his contacts—this when the infected industrial worker reports to her concerning his treatment. Instead, we find upon inquiry that many industrial nurses are merely doing clerical work on gonorrhea and syphilis. One nurse in a large plant said the only way she was permitted to participate was to record antisyphilitic treatments of individuals.

Where generalized public health nurses have been permitted to participate, they have been successful. In a certain city generalized public health nurses are doing epidemiological work in a large clinic. They are especially proficient because of their generalized preparation and experience in the art of interviewing newly-diagnosed cases. These nurses are doing generalized work in their present positions in this clinic. Every patient who sits before them is treated in his relationship with other members of the family group. We must always remem-

ber that each single person is a part of some family group.

Generalized nurses who have participated in the field work of extra-familial contact tracing in Maryland, Georgia, Connecticut, and Rhode Island have reported success. A nursing administrator who supervised this work stressed the importance of an efficient nursing consultant system which sent a supervisor into the field to demonstrate each step. She believes that the time spent in introducing the nurses to the service pays high dividends later. In one state where a great part of contact tracing both familial and extra-familial has been carried by public health nurses, the case finding ratio is 1 to 1 in gonorrhea and 1-plus to 1 in early syphilis. This commonwealth employs public health nurses to interview infected soldiers and sailors and follow up extra-familial contacts.

The potential value of public health nurses in this work is attested by such leaders in public health as Gladys Crain, co-author with Dr. Nels Nelson of the book, "Gonorrhea, Syphilis, and the Public Health." Miss Crain's work in gonorrhea and syphilis has been an inspiration to nurses everywhere. She says, "There is every reason to believe that generalized public health nurses will rise to new heights when their services in this field are enlisted universally."

From Maine to California, from Canada to the Gulf, public health nurses, 23,000 strong, are in the field, in clinics, in schools, in army camps, in naval hospitals. Five thousand perhaps are in wartime industry. Enlist the efforts of each one and you will not only improve extra-familial case finding in gonorrhea and syphilis, but you will also improve the mental health of gonorrhea and syphilis victims.

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An Understanding of Health in Nursing

By RUTH WEAVER HUBBARD, R.N.

What do we mean by developing "an understanding of *health in nursing*" on the part of the undergraduate student in the school of nursing?

THE CONCERN of the layman for good nursing service in his community is a natural one. That by virtue of this fundamental concern he should also be involved in nursing education is apparent to all who give the matter attention. As a civic-minded person, he feels both a responsibility and a desire to provide the safeguards and protections implied in adequate health service. As a consumer, he is further desirous of assurance that the services he may need are available. As a neighbor, he feels a special interest in making possible for others resources which they may be unable to provide for themselves.

These factors influence any of us, who, as residents of a village, town, or city, desire to do our part in the provision of adequate health services. This is the general basis of our concern. From this base we advance on different fronts to make our personal contributions where our interest and our skill enable us to serve best.

It is now many years since specific preparation, following a definite program, was accepted in our country as essential for women who plan to practice nursing outside their families. When our nation recognized this fact, we began to establish schools in large numbers. While in many instances one or two pioneering nurses upheld the educational standard in their schools with little help from others outside nursing, it was not infrequently a lay committee or board

who saw the need for good nursing for patients and developed the school which became the proving ground for the young nurse. In several outstanding instances it has been lay vision and effort which have founded and carried forward progressive schools of nursing. The layman who has a fundamental interest in the care of patients and their restoration to health finds himself alive to all that is involved in the educational program of the nurse who is to give this care or to supply the health supervision.

I can hear someone murmur at this point—is not professional education the rightful responsibility of the profession itself? Yes, I thoroughly agree that it is. But I believe that the group who desire both to provide and to use a professional service have a definite contribution to make to this preparation. By virtue of being laymen, who may wish to provide for others or to receive individually a particular service, they are in a position to know what is wanted and how far the available product meets specifications. If, then, we accept lay interest and to a degree lay assistance in nursing education, we can readily anticipate lay concern with trends in that education.

My experience does not prepare me to discuss undergraduate nursing education. I do work with students and with graduates, but most particularly with patients. Therefore, my approach is from the angle of our performance as nurses and the resultant consumer reac-

tion; in other words, our professional success. It is because I believe that this second quarter of the twentieth century has a particularly important responsibility toward the achievement of that success, that I have chosen to discuss the development of an understanding of health in nursing in the student.

The peculiar contribution of medicine to the twentieth century is the concept of the prevention of illness and the consequent promotion of health. The direct effect upon nursing of this change in outlook, based as it is upon new knowledge, has been to increase enormously the content of the nursing curriculum. Within a small space of fifty years, medicine has made such enormous strides in preventive and diagnostic procedures that the student of today must be familiar with a battery of tests and treatments largely unknown to the nurse who studied twenty years ago, and completely absent from the experience of the graduate of the eighties and nineties.

It is, I believe, correct to assume that the early schools of nursing dwelt much upon the art of making the patient comfortable in part at least because the outlook for recovery was often dark. Because we are so rightly concerned today with helping a patient to emerge promptly from his illness and return to his normal activity, we are perhaps in danger of minimizing the importance of the illness itself. We know, happily, that in an ever increasing number of instances recovery is assured. But we need to be on guard lest that knowledge influence us to regard the illness, in all its implications to the patient and his family, too lightly.

Differential diagnosis, now supported by an array of laboratory tests unknown to earlier practitioners, plays a large part in the hospital life of the patient and in turn, the experience of the student. Likewise, treatment both in terms of cure and of the prevention of further illness no longer consists alone of rest,

medication, or relatively simple procedures. The hospital, rightly the center of our medical program, has become a place as highly complicated as a modern industry, and the patient may feel as inert and anonymous as the piece of metal which enters an assembly line a simple bar and after some one hundred processes, emerges a ball bearing for an airplane. I am impressed by the great respect which manufacturers have for their materials. They respect their machines and tools also, but it is the raw material from which the product is to be constructed, its characteristics and possibilities, which form the basis of all their plans and procedures.

WHAT IS "HEALTH IN NURSING"?

Doctors and nurses feel the same way about patients, and into all the plans for diagnosis, treatment, and follow through, the patient himself, as a person, inevitably enters. To the student entering a school of nursing, human beings may not seem a new experience. She has lived and worked with people all her life, and often takes them much for granted. The new, challenging, enthralling, or amazing experiences of learning to be a nurse seem to be related to these tools or processes with which one works for and on the patient, rather than to the individual himself. And this is where we reach the core of our discussion. The understanding of health in nursing is our understanding of the patient as a person with a past and a future, belonging to a group to which he will return, having individual characteristics which influence all that may be done for him in his illness, and that in turn he may do for himself. This understanding enables us to develop an attitude which accepts the *patient* as the central figure in the picture, and his own action for himself—rather than ours for him—as the determining factor.

This understanding has a second aspect. It sees the hospital as related to

the whole national health program, as being one unit in the growing number of community services for health outside its walls. It realizes that the maintenance of good health for each individual involves the fully coördinated effort of all these agencies.

Nothing in this point of view is new or strange to the experienced doctor or the nurse. But its development in the young student requires forethought in planning and constant attention throughout the period of her undergraduate course. I have tried to indicate several reasons why this understanding may not develop spontaneously in the student nurse, although it is an essential part of her equipment. Lay people particularly will accept that point, since, when we fail to develop such understanding in our students, patients are the first to feel its absence. Without such understanding the most perfect thoughtfulness and skill fall short of their natural aim.

HOW GIVE THIS UNDERSTANDING?

To deal with *what* and *why* is less difficult than dealing with *how*. The very knowledges which make it possible for us to work positively with many of our health and sickness problems today have so multiplied the learning experiences and complicated the clinical situations for the student that time for any additional effort is at a premium. The desired attitude itself is not readily tangible, and therefore does not lend itself to unit presentation. Its appearance has been found to follow a series of carefully arranged experiences which do not adhere to an outline as neatly as does the presentation of factual material or provision for the development of a skill. It needs to permeate the entire curriculum and its growth is directly dependent upon its presence in the faculty and graduate staff of the institution, as well as upon their initiative and skill in its introduction to others.

Do I seem to be discussing some vague and ethereal quality? I would not have it so. We are considering the ability of the student to recognize that the illness or problem which brings the patient to the hospital or clinic is but a thread in the whole fabric of that individual's life. Whatever is done for him will be but a part of his own existence. But it *is* a *part*, and it is to insure the greatest good to the individual from this part that we aspire. We need, then, to make provision for the student nurse's appreciation of this fact. While her own effort is primarily concerned with her direct service to patients, she can grow in appreciation and understanding of two things in her educational preparation: (1) the patient as a person (2) the hospital as a part of a larger concerted community health program.

MANY STUDENT EXPERIENCES NEEDED

These two understandings comprise the appreciation of health in nursing which we desire. To come by the first, we must assure the student opportunity to learn about people as well as diseases in nursing, about the way people behave as well as the way diseases behave. We must help her always to see John, who is ten and has rheumatic fever—and never just a case of rheumatic fever. In seeing John she needs to see also John's family, his home, his interests, and his special capacities.

To achieve the second, we must undertake to acquaint the student with the community effort for health which goes on outside her hospital walls. This acquaintance should be more than a nodding one. To be useful it should be the basis of a working relationship. Then the hospital takes its place in the whole pattern of community health and the work done there becomes a part of a larger effort. Thus John, to carry the illustration further, is not lost when he leaves the hospital. Whether he goes to a convalescent home or to his own

family, his own doctor, and the public health nurse, the student knows in more than a vague fashion what we mean by "follow through."

The realization of this part of the health in nursing aim has been achieved variously in the past, and it is my conviction that the future holds a wider variety of devices. We have not developed a standard procedure. Even the time-honored affiliation has not been universal among schools or students. It is frankly impossible to make it so for numerical reasons alone. Opinion is divided between those who seek a readily standardized device and those who feel that individual initiative in local situations will be most productive. Certainly much more experimentation is called for before we standardize our procedure here. In fact, it may never be wise to do so.

Whatever the methods for enabling a student to develop an understanding of the patient as an individual and of the health efforts in the community which serve him, I believe they should reach *every* student in *each* school of nursing. This is important because such understanding is essential for the graduate practice of nursing in any field. At one time it was considered desirable to provide for it through affiliation with a local visiting nurse association. The day is well passed when such practice is accepted as being *all* that is necessary. In fact, we now feel strongly that the student who has not developed this understanding cannot profitably use an affiliation.

NEW WAYS CAN BE FOUND

As our own understanding of what the presence of this attitude means in nursing increases, we shall find new ways to provide for its appearance. The ways and means are less essential than the conviction that they can and must be found. It is the laymen, as board members of public health nursing agen-

cies, who know how vital this outlook is for their staffs and how desirable in the young recruit. It is the laymen as board members of schools of nursing and hospitals, whose understanding support will enable their directors and faculties to develop the methods most practical for their schools.

Of one thing I am certain—nothing is so needed in nursing education today. In a time when many procedures must be evaluated, and all that are less than essential discarded, provision for this understanding must be safeguarded. Only so can we be certain that nursing is enabled to make its full contribution to community health.

Much good work has already been done in this area. Inspired by the leadership of the *Curriculum Guide for Schools of Nursing*, nursing educators in widely scattered places, with varying plans, are endeavoring to provide for the point of view we seek. We hear discussions on integration. We learn that a special instructor with a public health background is desirable. We read that new variations of public health affiliation are helpful, that some guided visits to homes of patients may awaken understanding. We find that nursing instructors and public health nurses are working on joint committees in our several states to share experiences and to develop new methods. The National League of Nursing Education and the National Organization for Public Health Nursing have formed a joint committee to further this aim. Reports of experiments are beginning to appear in our professional literature, while Harriet Frost's direct and understanding book, *Nursing in Sickness and in Health*, (New York, The Macmillan Company, 1939) continues to inspire student and graduate alike. This brief and incomplete enumeration serves but to indicate that the goal has been accepted in many quarters. Most important of all, results are visible in some of our students

and young graduates, and when they display this understanding we know that our efforts have been justified.

KNOW THE PATIENT

Years ago a great physician, Sir William Osler, who was also a gifted teacher, said, "... have no teaching without a patient for a text, and the best teaching is that taught by the patient himself." Years later, as a young graduate, I heard a gifted Scotch physician, Sir James Mackenzie, explain that no patient cared about the diagnosis of his illness as such, but every patient was deeply concerned to know what his illness meant to him and to his own work in life. These two thoughts seem to give us our cue for the student who seeks to understand health in nursing. She will strive first to know her patient and to learn from him that she may help him, realizing that his illness is but a part of all he has been or hopes to be. Being aware that in her service she is privileged to share in helping toward a future in which she may not participate, she will endeavor to assist her patient to be prepared for the next step—outside the hospital, where other health workers carry through.

We live in an age when science has wiped out distance. We may speak with

someone halfway across the world in a moment of time. We can fly across a continent in a few hours. But we have not yet bridged the gaps which our patients find in passing from one stage of illness to another, or one type of care to another. We have countless devices which exist to do these things. As yet the gaps remain. Maynard Kreuger, in his inspiring address at this Biennial Convention, urged us as Americans to close the gaps between what we *say* we do and what we *do*. His challenge comes directly home to us in nursing education! We need to enable our students to achieve and to apply an understanding of patients as people, and of health as more than an absence of disease.

The nurse who is the companion of the patient in all stages and places of his illness has a rare opportunity to build bridges. Let us, therefore, give to our students understanding—as well as knowledge—of health in nursing, so that of the nurse it may be truly said, "She openeth her mouth with wisdom and in her tongue is the law of kindness."

Presented before the Joint Session of National League of Nursing Education and N.O.P.H.N. for lay groups, on "How the Layman Can Promote Better Nursing Education," Biennial Convention, Chicago, Illinois, May 20, 1942.

TO BE DEMOCRATIC implies that purposive behavior is continuously directed towards the fulfillment of human needs. Here again social work's record is admirable. I am filled with pride, for example, when I think of the careers of such agencies as the National Child Labor Committee, or the American Red Cross, or the National Organization for Public Health Nursing, to name a minimum number. The pattern has become familiar to Americans although it cannot be said to exist elsewhere in the same degree. First, there is a consciousness of human need, next a committee, then a budget, and finally, people are set to work to meet the need.

—Eduard C. Lindeman, "The Interpreter's Task," *Channels*, September 1942.

The Baby in a Blackout

By

HAZEL CORBIN, R.N.



THE THREAT of community calamity by blitz or sabotage in this country has inspired some gadget-loving Americans to work out elaborate and special precautions for the protection of this and that, such as cats and dogs, monkeys in the zoo, alligators or parakeets. Babies too have come in for their share of the so-called protective devices and plans, some of which make the silly inventions of Rube Goldberg seem positively sane. The plans of these gadgeteers for the protection of a baby call for a mother with enough arms for an octopus to carry all the equipment, which due to rulings by OPA, WPB, *et al.*, can't be bought in the stores.

Confused with all these gadgets and elaborate plans, mothers are turning to public health nurses for advice. They ask a simple question, "How can I best protect my baby in an emergency?" They expect a simple answer, a practical answer. Nurses who have done some thinking about this matter and checked up with those who have experienced wartime emergencies are agreed that there are six dangers from which a baby must be protected. They are: insecurity, con-

cussion, dust, lack of food, exposure to cold and disease, gas.

A mother should be helped to think through carefully the situation in her own home—if and when. . . . She should devise the simplest plan possible to protect the baby from these six dangers.

A baby, no matter how small, knows when unusual things are happening to him. A feeling of security is one of the most important things in the world for him. There is much that the mother can do in an air raid to give him that feeling. The mother herself can be outwardly calm, even though inwardly disturbed. Panic, like the measles, is communicable. If the baby feels that his mother has lost her assured manner in his care, he will be insecure. Self-discipline and a philosophic outlook, typified by the Mrs. Minivers, are important during wartime. That is the stuff of which true morale is built.

There are two sets of circumstances which may face a mother. If she lives in a private house or an apartment from which she does not have to move by order of the protective services, she should choose the safest spot in her

house. In this spot she should keep a sturdy table, and a blanket, quilt, or curtain, ready for instant use, also a few cans of food and a can opener. If she must leave her home for a safer place, arrangements should be worked out with the air raid warden, so that a table there is readily available.

In either case the mother should have a basket or bag, packed with the following things, and ready for instant use: diapers, pads, a baby sweater, several baby blankets, a flashlight. There should always be a supply of freshly-boiled water and sterilized nipples in a covered jar. If the baby is on a formula, enough bottles for several feedings should be ready at all times, in the refrigerator.

If and when the warning sounds, the mother should slip on a coat or wrap, and pick up the baby—in his bassinette if possible. Then she should get the basket or bag with the baby's supplies in it, stop at the refrigerator for the water and the formula and put them in the basket or bag. She then calmly proceeds to the selected safe spot, after going to the toilet. The baby's bassinette goes on the floor, under the table. The blanket, quilt, or curtain is draped over the table so that it hangs down to the floor on all four sides, to make a snug little den. One side should then be folded back. It is only let down, if and when. . . . This arrangement will help to protect the baby from harmful and irritating dust and grime, gas, or splinters. It will also help to soften some of the terrific concussions of possible nearby explosions.

The mother should make herself at home on the floor with the baby and feed

him as near his regular schedule as possible. The mother who nurses her baby has a great advantage at a time like this. She has no formula to worry about, to transport, and keep sweet. She knows that her milk is clean and at the right temperature for the baby. A mother who artificially feeds her baby can take the chill off the bottle by placing it under her arm for a time.

In the mother's concern for her baby she must not forget herself. If the incident lasts for a long time she will need food. This is where the little cache of canned food, placed in the safe spot—just in case—comes in handy.

To do these things calmly and efficiently requires a few rehearsals, so that even if the mother may be inwardly disturbed, she will have no indecision about what to do when the time comes, and it will not be a frightening and strange experience for the baby. If there are other small children in the home, each should be given something to carry or something to do, to take their minds from the dangers and give them a feeling of shared responsibility.

All of these arrangements presuppose that the mother will have no assistance from her husband, relatives, or friends. It is best not to depend on any help whatever, for war emergencies can and do come at the most unexpected moments with little or no time to secure assistance. If the mother knows that she can protect the baby herself without assistance, her feeling of calmness and assurance will be transmitted to all those about her.

Photograph, Procter and Gamble.

Syphilis Follow-up Among Selectees

By ANNE BURNS, R.N.

A VENEREAL disease program utilizing Selective Service has been developed as part of the generalized nursing program of a combined official and nonofficial agency in Columbus, Ohio. Selective Service, with its official authority for location and control of its men, has proved to be an excellent source of case-finding for syphilis. Especially helpful is the fact that selection under the draft is not limited to any economic stratum of society.

The plan for follow-up of our Selective Service registrants with positive serology is as follows: The physical examinations of selectees before induction in the army include serologic tests for syphilis. Their blood is examined at the state laboratory, where both Kahn and Kline tests are done. TriPLICATE reports are prepared on all positive serologies. One is forwarded to the local draft board; one is sent to the local health department; and one is kept on file at the Ohio Department of Health.

When a positive serology report is received by our City Department of Health, it is referred to the venereal disease department of the nursing division. The case is cleared first with our Selective Service file to determine whether the blood test may be a first or second one, then through our two clinics to ascertain whether the patient is or has been under treatment. If he is not under treatment, a carefully stated letter—not a form letter—is sent giving him an appointment with the health commissioner to discuss “the result of your recent physical examination for Selective Service.”

The selectee is interviewed by the health commissioner. He is given a

brief interpretation of his condition, and literature to read on the subject. He is advised to have a physical examination and additional laboratory tests. If the selectee cannot afford the care of a private physician, he is referred to one of the two available clinics. It is interesting to note that of the 731 cases reported, 336 were referred to private physicians and 315 to clinics. The remainder were a miscellaneous group: eight negative upon reexamination, one third impossible to locate, almost two-thirds moved from Columbus (in each such case notification was made to the man's present local health department).

All information in regard to the case is recorded in the back of the serology report and retained in the venereal disease file of the nursing division. This eliminates duplicate records. If a home visit is made, a nursing record similar to our other records for venereal disease patients is made and the visit is noted on the serology report.

Physicians and clinics are asked every two months for reports on the status of each patient. A form letter is used for the purpose, with a self-addressed envelope enclosed. In the beginning we telephoned the physicians, but this was a time-consuming process. We now have 97 physicians on our mailing list.

If the man is found not to be under regular treatment, the following procedure is carried out:

1. He is notified by mail of his need for regular medical care and advised to inform the nurse at the health department regarding his future plans.

2. If this is not effective, a home visit by a nurse in our generalized nursing service is made.

3. If there are still no results, the draft board is notified of the selectee's failure to respond and the man is usually called into the office to discuss the importance of regular medical care.

At regular intervals we personally visit each of the draft boards and check our list of registrants with them. We give the boards the names of the patients' physicians or clinics in which selectees are receiving treatment and suggest that any additional medical information be secured directly from the doctors.

CLERKS ARE HELPFUL

We discuss with the Selective Service clerks the objectives and policies of the health department program for venereal disease control and how we can coordinate our services. This personal contact has proved to be valuable in developing a good working relationship, for many of these clerks had never had an understanding of syphilis or gonorrhea. For example, several had been insistent that we isolate men with a diagnosis of late latent syphilis, because they were delinquent in taking treatments. We also ask the clerks to report to us all men deferred because of gonorrheal infection so that we can assist them in obtaining the necessary treatment and can make an epidemiological investigation.

We have had splendid cooperation from the draft boards. They have been able to give us information regarding addresses, employment, marital status, and classification of the men. In turn we notify them when the patient can be released for army service under the regulations set up by the Selective Service System.

Columbus, Ohio, has a population of 306,000, and there are 24 local draft boards. Out of 16,000 men examined, 731 individuals with positive serology have been reported to us. The percent of selectees with positive serology reported in the State of Ohio is 1.78 as compared to 3.15 percent in the city of Columbus. The Negro selectees are 16.05 percent positive in the state as compared to 15.37 percent in the city. Of the 731 men there were 8 found to be negative on reexamination, and finally diagnosed as nonsyphilitic.

It has been said that statistical studies reveal that there are at least three persons exposed to infection for every one who comes for treatment, and it is usually true that two of the three need treatment but have not been aware that they needed it, or how and where to get it. One can easily understand that the 731 patients discovered and treated through Selective Service are a source of help in finding additional patients who are in need of treatment.

Our objectives as public health nurses in this program are:

1. Case-finding—remembering that the key person in the whole program is the individual patient, the known case. Without his active participation, the work of all other agencies is of but temporary value.
2. Securing sufficient treatment facilities.
3. Keeping the patients under treatment either in the clinic or with the private physician.
4. Making an epidemiological investigation of each case.
5. Continuing education of the public.

Mrs. C's Share-the-Work Plan

By CAROLYN M. WILCOX, R.N.

MRS. C. drew this picture and the nurse found it tacked on her kitchen door, down low. Her boys were too little to read, so it was done in different colored crayons and in picture form instead of words. It concerns the work the boys do in the house. Each boy has his own color—red, green, blue, or purple—and the star is a reward for a good week. They don't always get a star, for they're just ordinary, noisy boys and as liable to let things ride as the next one. Eddie, only two, was really too small to be listed, but the others didn't want him left out and they had to hunt around and find jobs for him too. His jobs are picking up shoes and slippers. The funny thing on the end is a spoon. He dries them.

The C.'s live in an unattractive, bare-looking house on the edge of the town, surrounded mostly by factories and mud. The house is in poor repair and not very clean in the entrance. They have the lower floor, which consists of three, very crowded rooms and a bathroom. The kitchen is dark and crowded and gives a general appearance of untidiness, although it is actually clean. As in the picture in Michael's list, the sink has two faucets, but only one works—it's cold. An old-fashioned pot-belly wood stove gives the only heat. That accounts for the woodpile that Michael keeps supplied and Jim keeps picked up around the edges.







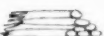


To keep four boys, a dog, a velocipede, a swing slung in between the kitchen and bedroom doorway, a large express wagon, a washing machine and a victrola—not to mention the necessity of putting up an ironing board now and then—tidy in three rooms would obviously be beyond human capability. And luckily, Mrs. C.

seems both very human and very capable. She is apparently blessed with a sense of humor and an admirable way of handling children. She hasn't had a great deal of schooling and they are obviously quite poor, but surely she is giving her four boys a rich heritage in spite of their very poor surroundings.

Mr. and Mrs. C. have the front room for their bedroom and a family living room. The bed boasts a patchwork cover made by Mrs. C. One would hesitate to call it a quilt for she had no inside material and uses it outside a worn-out comforter. It is taken off periodically for washing and then snapped on again.

The four boys from Eddie to Michael, who is almost eight, have the other room. The two big fellows sleep in the double bed and each of the little ones has a crib to himself. There is no room for swinging cats or anything else. The windows are hung with blue checked oilcloth topped by a plain blue valance of the same material. The only speck of wall space is used for shelves made of egg crates covered with the same oilcloth. These are used for clothes and toys. All the spreads are of unbleached muslin with a large anchor appliqued in blue-checked gingham. Hanging on the closet door is a blackboard which saves the walls from artistic efforts. Above it is a bulletin board for special things brought from school. It's just a piece of insulation material salvaged from an old ice box, but it lends itself to thumbtacks very well. It's plain to see that Mrs. C. tries out the things she reads in magazines on homemaking!

She reads other things too, for she has a stack of books and pamphlets given her by the public health nurse, the insur-

	FEBRUARY			
	WEEKDAYS		SATURDAYS	
MICHAEL	 			  ☆ H7
JOHN				  ☆ H7
JIM		TOYS		   ☆ H7
EDDIE	  			 ☆ H7

Mrs. C's Work Calendar

ance agent, and government pamphlets sent from Washington. She writes to a factory for odd assortments of wool called "ash-barrel yarn" and makes sweaters, caps, socks, and mittens of whatever kind of wool they send. The boys have paper-covered books, also ordered by lot at 12 cents each, on birds, trees, animals, plants, and everything else you can imagine.

Some of the pictures in the boys' work-calendar are a little hard to understand, such as the straight lines in Michael's row. They are the pipes he keeps clean. Meg, the dog, is in his row too—the four-legged object. The oddly-shaped object at the beginning of four-year-old Jim's row represents the pieces of paper he picks up. Next come the soiled night clothes that have to be collected. The bit of humanity down the line is the baby, Eddie—Jim has to keep him out of mischief. The pictures beside the seven at the end of each row mean bed-time.

Mrs. C. is proud to show the victrola records she has bought at special sales—all the semi-classics, Strauss, the famous minuets, and in-between things. She knows that if the boys hear them while they're little they'll absorb all the good things without realizing that they're

cutting their musical eyeteeth in a painless manner. As she brought the records out, she explained, "I'm one of them dames that goes in for this classical stuff."

When asked if she wouldn't like to move into one of the new housing projects, her eyes sparkled. But her answer was, "We're the kind of people who want a farm someday with our own shack on it and be able to keep chickens. We have goats out back now." Judging by the appearance of the boys, goat's-milk agrees with them, so perhaps they're better off. They are certainly better off in a number of ways than some of the boys we see whose mothers scream—and I really mean scream—at them as they enter the door, "The next time you bring mud in on my clean floor I'm gonna hit ya!" The mothers are right in one way, the floors *are* clean, in fact, waxed within an inch of your life. But boys need more than clean floors and Mrs. C. knows it.

The living conditions at the C. house are far from ideal, but it's the rare person like Mrs. C. who makes public health nursing such a *very* satisfying job. The nurse can depend upon it—what she teaches here will not be forgotten. Things taught are used again in similar

circumstances and revised to meet the current need. It seeps over to the boys too—they asked the nurse to teach them to make paper bags the way she does and now they're all making newspaper bags fast and furiously. Their mother tells the other children to keep away from the one who is sick because he has germs and she has pinned newspapers over the side of the sick crib (whoever is sick promptly gets a crib to himself) to keep the others out of sneeze-shot. All this is done before the nurse arrives. At the moment of writing, Jim is walking around the house looking, but apparently not feeling, rather silly in an old knit baby cap tied under his chin. It's to

keep the cotton in the bad ears he's been having and keep the draughts out.

When Mrs. C. heard that there was a story being written about her calendar, she said to be sure to tell the other mothers to let the boys choose their jobs. That saves bickering and no one feels that he's been given a less attractive job than the others. She uses the simplest method of voting. Each piece of work goes to whoever shouts loudest for it.

Mrs. C. is, without exaggeration, the answer to a prayer, a public health nurse's prayer. At the moment she is very delighted at the prospect of a fifth child, already on the way. She wants to knit something pink!

EXPERT CARE FOR BONNIE

THIS RECORD of an actual telephone conversation comes from the District Nursing Association of Portland, Maine, whose director, Velma V. Pettiner, rightly thought that others "might also find it amusing."

TELEPHONE: Buzz, buzz.

NURSE: Visiting Nurse Association.

MRS. SMITH: This is Mrs. Smith calling. I had one of your nurses visit me last fall after my operation. Well, it's not for myself I'm calling today. Dr. Black ordered an enema for Bonnie and I wonder if one of the nurses would come over and help me give it. I suggested that Bonnie go to the hospital but since she's eight years old the doctor doesn't think she should be moved. I asked him about calling the visiting nurse and he said, "Well, you can try, but I don't know whether they attend dogs." I do hope you'll help me out. Of course, I'll be only too glad to pay the regular fee.

NURSE: I'm sorry Bonnie is sick, Mrs. Smith. You were wise to call your doctor right away.

But we have only six nurses and it takes all their time to care for the sick people here in the community. In fact, many times we wish we had an extra nurse. Our director feels we should give only those services we can do adequately, so I'm afraid you'll have to call Dr. Black again and tell him we won't be able to help you with this. I'm sure he can suggest someone who can.

MRS. SMITH: I understand, but I did so enjoy your nurse that I thought I'd feel better if she could come. I'll call Dr. Black and tell him.

NURSE: (*Hangs up.*) Oh, dear. Now just suppose . . . Well, I hope this doesn't give our director any new ideas on how to develop our pay service. She does say we must meet our community needs. But if dogs are to be included . . . Oh, dear!

Diseases In Warm Climates

By ERNEST CARROLL FAUST, Ph.D.

KALA-AZAR and African sleeping sickness are diseases produced by protozoa referred to as hemoflagellates, organisms with a thread-like locomotor organ which are found in the blood stream.

KALA-AZAR

The etiologic agent of kala-azar is *Leishmania donovani*. This disease is probably transmitted by the true sandfly, *Phlebotomus*, and is prevalent in North China, Eastern India, Iraq, Iran, Syria, Palestine, Southern Europe, in numerous small foci in Egypt and other parts of Africa and in South America. It is found especially in children in China and the Mediterranean basin. It causes a visceral disease, with enlargement of the spleen, liver, lymph nodes, and engorgement of the bone marrow, anemia, and leukopenia with lymphocytosis. It is commonly complicated with broncho-pneumonia. Antimony drugs are specific. Prevention of this disease has as yet made no satisfactory progress.

AFRICAN SLEEPING SICKNESS

African sleeping sickness is caused by two trypanosomes, *Trypanosoma gambiense* and *T. rhodesiense*, which are transmitted by the tsetse fly, *Glossina*. These infections are prevalent in extensive belts in West, Central, and East Africa. At first confined to the blood stream, the organisms soon enter and multiply in the lymph nodes, and later enter the central nervous system. It is the last stage which is responsible for the term "sleeping sickness," due to inflammatory and degenerative changes in the brain and spinal cord. Arsenical preparations including tryparsamide and germanin are the therapeutics of choice,

but are of little help in advanced stages of the disease. Prophylactic measures are not thoroughly successful, but include early treatment of all diagnosed cases, quarantine, and fumigation of vehicles leaving endemic foci and burning of bush in which the tsetse flies may hide.

HELMINTHIC INFECTIONS

Helminthic infections are caused by parasitic worms called helminths. There are several dozen species which infect man, but aside from pinworms (*Enterobius vermicularis*), helminths usually do not constitute an important clinical or public health problem in cool climates. In warm climates, however, environmental and sanitary conditions frequently cooperate to make helminthic infections a major medical and public health problem. Three important types will be briefly considered.

HOOKWORM DISEASE

A quarter of a century ago hookworm disease was a most incapacitating and frequently fatal infection in our Southern States. It is caused by *Necator americanus* (the "American murderer") and is contracted from direct exposure of the bare skin, such as that of the feet, to soil previously contaminated by human feces and soon thereafter containing the infective-stage hookworm larvæ. Intensive hookworm campaigns throughout the hookworm belt of the United States carried on jointly by the Rockefeller Foundation and the several state departments of health have reduced this menace to a very small fraction of its 1915 status. This has been accomplished by diagnosis and specific treatment of all discovered cases of infection, together with installation of sanitary

sewage disposal in towns and sanitary privies in rural areas. There is still light hookworm infection throughout the South but hookworm disease with its production of profound anemia and numerous complications is not commonly seen today.

In contrast to the success attendant on hookworm prevention in the Southern United States, attempts to reduce the infection in even more highly endemic areas throughout the countries south of us and in similar latitudes elsewhere in the world have been less effective, even though public health officials have worked valiantly. Possibly several more decades must elapse before mass education will bring about the desired results.

FILARIASIS

This disease is due to infection with a small roundworm, *Wuchereria bancrofti*, the adults of which are coiled in pairs or groups in lymphatic vessels or lymphoid tissue, most frequently in the groin or retroperitoneal region of the trunk. The embryos, the *microfilariae*, are minute snakelike organisms which gain access to the blood stream and typically surge through the peripheral vessels at night. The adult worms in the course of a few years usually die and set up an intense local inflammatory reaction, with filarial lymphangitis, obstruction of the lymphatic vessels, and consequent production of varicosities, frequently elephantiasis. This disease is rarely seen in the United States but is common in Puerto Rico, Jamaica, and elsewhere in warm climates. It is transmitted by the tropical house mosquito, *Culex fatigans*, as well as other mosquitoes. Once the infection has been contracted there is little available relief for the patient, although surgical reduction is sometimes temporarily helpful. The only ultimate practical control measure is the eradication of all breeding places of the mosquitoes involved.

BLOOD-FLUKE INFECTION

Blood-fluke infection, technically known as *schistosomiasis*, is due to three species of delicate threadlike worms which live typically in the venules draining the intestinal tract (*i.e.*, mesenteric venous circulation) and the urinary and pelvic organs (*i.e.*, vesical and pelvic plexuses). The Asiatic blood fluke (*Schistosoma japonicum*) lives in the venules of the small bowel; Manson's blood fluke (*Schistosoma mansoni*), in those of the large bowel, and the vesical blood fluke (*Schistosoma haematobium*), in the vesical and pelvic plexuses. By-products of these worms cause toxic fevers, with urticaria, and a high eosinophilia; their eggs filter through from the blood vessels into the lumina of the intestine or urinary bladder with escape of blood and consequent dysentery (if intestinal) or hematuria (if vesical). When the feces or urine of infected individuals get into fresh water, as in a pond, canal, or irrigation ditch, the eggs hatch and the free-swimming larvæ search out an appropriate intermediate host, which of necessity is some particular species of water snail. The snail is invaded, the parasite multiplies within the snail's soft tissues, and in a month or so myriads of fork-tailed larvæ escape into the water. These larvæ are infective for human beings who wade, bathe, or wash in such infected water. Invasion is by the skin route. After a devious course of migration through the tissues of the body some of the larvæ succeed in reaching the portal blood vessels, where they feed, grow, and then migrate out to the venules where they develop into adults. Here they mate and begin to lay eggs.

Asiatic schistosomiasis is highly endemic in Central and South China and in a few smaller foci elsewhere in the Far East. Manson's schistosomiasis has an extensive distribution in the West Indies from Puerto Rico to the South American coast, in Venezuela, Dutch Guiana, and vast areas of Northern Brazil. It is also

prevalent in many parts of Africa. Vesical schistosomiasis practically covers Africa; it is prevalent in Syria, Palestine, parts of Arabia, and Iraq. None of these diseases occurs autochthonously in North America, Mexico, or Central America, because the appropriate snails are not found in these latter countries. Antimony drugs are specific for blood fluke infection but repeated treatment is frequently required before cure can be effected.

All of these types of schistosomiasis are disabling, are frequently beyond therapeutic aid insofar as restoration of vital tissue is concerned, and are invariably fatal without specific treatment. There are several possible methods of control. Individuals should keep out of infected water. Feces and urine should not reach the snail-inhabited waterways in an unsterilized condition. Snails should be eradicated from endemic foci. All infected individuals should be treated until cured. In irrigated areas most snails will be killed if the water is diverted into other channels for a few months each year and the canals allowed to dry out. Many snails will be killed by application of copper sulphate (1 part in 50,000 of estimated water volume). In this last connection it is important to note that in Michigan, Wisconsin, and Minnesota, many small lakes are responsible each summer for schistosome dermatitis, due to nonhuman blood fluke larvæ which escape from snails and gain entry into the human skin, causing pruritus and a maculopapular rash which proceeds to vesicle formation.

LEPROSY

This disease was probably introduced into the United States from Africa, Mexico, and China, and possibly also from Europe. Endemically new cases rarely appear except in the region of the Gulf States, particularly Louisiana. The epidemiology of leprosy is poorly understood but in Louisiana the disease tends to appear in successive generations of a

family which maintains residence in the same habitat. The disease is not readily contracted by direct contact with leper patients—in other words, it is not contagious in the ordinary sense of that term. In Mexico and Tropical America the disease is much more prevalent than in the Southern United States. Cure is difficult and specific means of prevention are at present not known.

SYPHILIS AND YAWS

It is not necessary to mention to public health nurses the danger of syphilis and other venereal diseases which beset our troops as a result of allowing them contact with the prostitutes who parasitize military camps or nearby towns. However, attention should be called to the etiologically related disease, yaws or frambesia, produced by the spirochete *Treponema pertenue* which is prevalent in the American tropics. This infection produces primary skin lesions, not unlike the secondary skin lesions in syphilis, and later deeper erosive lesions of cartilage and bone. Probably yaws is most commonly acquired by direct contact, but there is experimental evidence that flies feeding on open lesions may serve as mechanical vectors to clean individuals. Yaws is not fundamentally a so-called venereal disease.

MYCOTIC INFECTIONS

There are various species of fungi which parasitize the human body, producing either skin infection (dermatomycosis) or systemic infection. Among these are the skin infections of athlete's foot, of the hairs of the head, beard, etc., and those referred to as ringworm. Systemic mycoses include actinomycosis, blastomycosis, coccidioidal granuloma, and histoplasmosis. All of these are especially prevalent in warm climates and most of them prefer a humid atmosphere. Wherever these infections flourish, meticulous care must be taken to keep the skin clean, to have cuts and abrasions adequately disinfected and properly

dressed, and to guard against inhalation of fungous spores into the respiratory tract.

ARTHROPOD INFESTATION OF SKIN

Only passing reference will be made to the annoyance and at times allergic manifestations caused by blood-sucking flies and mosquitoes, fleas, lice, mites, and ticks, due to introduction of small amounts of their saliva into the skin at the time they prepare to take a blood meal. Actual invasion of the skin is produced by the mangle or sarcoptic mite, *Sarcoptes scabiei*, by the maggots of several species of filth flies, and by the tropical flea, *Tunga penetrans*, called the "chigo" by the Indians. All of these skin infestations are particularly prevalent in warm climates. Not only do they cause pain and at times irreparable disfigurement but they allow entry of pyogenic bacteria which complicate the wound and may result in septicemia. Since it is frequently impossible to prevent the initial infestations, steps should be taken to remove the invading organism as soon as possible and to keep the wound from becoming septic by sterile or antiseptic dressings.

RESPIRATORY DISEASES

Natives in warm climates, especially in congested living quarters, are peculiarly susceptible to infection with the respiratory diseases of the white race, such as pneumonia, influenza, and tuberculosis. Deaths resulting from these diseases constitute a large percentage of total deaths in the tropics.

NUTRITIONAL DISEASES

Malnutrition is prevalent throughout extensive areas of the United States, especially in the South, in time of peace. Under conditions of war much greater care must be exercised to preserve a nutritional balance. In the American tropics pellagra, beriberi, rickets, scurvy, and in the white man, sprue, are common in every medical clinic. One or more of

these deficiency diseases contribute their threshold of lowered resistance to amebiasis, malaria, hookworm disease, pneumonia, influenza, tuberculosis, and probably even to leprosy.

SUMMARY

An attempt has been made to show that diseases in warm climates are not usually different etiologically from diseases in temperate areas of the world. However, conditions of temperature and moisture in the tropics tend to produce plant and animal life luxuriantly and profligately. This provides an unusually fine environment for the growth of pathogenic microorganisms, as well as for venenating animals. On the other hand, human metabolic activity is slowed down, due for the most part perhaps to man's difficulty in losing metabolic heat. Voluntarily man exercises less, becomes careless of his food, drink, and clothing, and his habits of personal and group hygiene. All of these factors favor the development of endemic disease and to an even greater degree disease in epidemic form.

Metabolic diseases in the tropics include the deficiency group and these in turn are in no small measure responsible for digestive disturbances, cardiorrenal difficulties, and endocrine disorders.

Food and drink in warm climates are always subject to suspicion. Raw salads, semi-cold meats, and vegetables unless freshly cooked, milk, and unboiled water are commonly suspect and may contain the agents of dysentery, typhoid, cholera in endemic areas, as well as certain fluke and roundworm infections.

The skin functions imperfectly, becomes blocked with excretory wastes, is readily invaded by pyogenic bacteria and pathogenic fungi. It also becomes the portal of entry for hookworm larvæ from the soil and blood-fluke larvæ from "infected water." Myriads of insect pests attack man's skin for nourishment and in so doing many of them mechan-

ically or as incubating agents transmit disease-producing microorganisms. The toxic saliva or the venom of arthropods and snakes, introduced into the skin, produces repeated inconvenience or dramatic effects on the blood vessels, the contained blood, and frequently on the peripheral and central nervous system.

The primitive sanitation of natives in the tropics, resulting from ignorance and inertia, is a primary cause for disease conditions. Congestion in human habitations favors tuberculosis, pneumonia, and influenza, and provides a background for epidemics of typhus and plague. Human excreta contain the source for propagation of enteric diseases of microorganismal etiology, and for most worm infections. Improper disposal of these wastes in the tropics provides abundant opportunity for perpetuation of these diseases in endemic or epidemic form. Black peoples and American Indians are peculiarly susceptible to the white man's diseases. The white man in turn is especially attacked by malaria, yellow fever, and hookworm disease, to

which he has built up little racial resistance.

In the Southern United States success has attended sustained efforts to reduce malaria, typhoid fever, and hookworm disease. Epidemic typhus, plague, cholera, and yellow fever have been eradicated, but endemic typhus and amebic and bacillary dysentery have yet to be attacked on a major scale. In the American tropics, no disease has been brought under control except urban yellow fever. Malnutrition has constituted an important public health problem in the Southern United States. In the tropics it complicates almost every disease. While individuals of intelligence may safeguard their own health in warm climates by following certain rigid rules, the public health aspects of disease are today the most important in all warm climates. Prevention is not necessarily easier than cure but in the long run will be the only guarantee of sustained health.

This completes Dr. Faust's "Diseases in Warm Climates," the first half of which appeared in December PUBLIC HEALTH NURSING.

THE AMERICAN JOURNAL OF NURSING FOR JANUARY

The Boston Fire	Grace Parker Follett, R.N.
Asiatic Cholera	M. Fernan-Nunez, M.D.
The Untrained Patient Remains Uncured	Louise A. Lincoln, R.N.
Intubation in Gastric Surgery	Kathleen Barrett, R.N.
The Hospital and the Community	
Breast Milk	I. McKy Chamberlain, M.D.
War Relocation Projects	Catherine S. Scott
Men Nurses in the U.S. Navy	W. P. Briggs
Nursing—A Critical Analysis	Joseph W. Mountain, M.D.
How Safe Is Your Mask?	Virginia Betzold, R.N.
ARC Accelerates Recruitment	Gertrude Banfield, R.N.
The Army Calls All Eligible Nurses	
State Leagues and State Boards	Charlotte Skooglund, R.N.
Suggested Plan for Acceleration of Clinical Learning	R. Louise McManus, R.N.
Suggested Minimum Qualifications of Personnel for Nursing Schools and Hospital Nursing Services	
Centralized Preclinical Teaching	Helen J. Leader, R.N.
Private Don Jones' Baby	Anna R. Moore, R.N., and Marie Chard, R.N.
Accelerating Education Programs	

Iowa Trainee Program

By MARIE NEUSCHAEFER, R.N.

IN THE EARLY fall of 1941 eight vacancies in Iowa county public health nursing services defied all efforts to obtain replacements. In a short period of time six more counties elected to have a county public health nursing service, bringing the total number of vacancies to 14.

Because the establishment of county public health nursing services has been one of the major objectives of the State's program, 14 vacancies which apparently could not be filled by the usual processes, presented a real challenge. It became apparent that if we were to maintain the interest and participation of our community groups, and provide for the much needed nursing service, a new procedure for obtaining nurses must be developed in a short period of time.

The plan which is about to be described was first approved by the staff of the state Division of Public Health Nursing, the commissioner of health, Dr. Walter L. Bierring, and the directors of the other divisions. Approval was obtained from the area office of the United States Public Health Service for the expenditure of funds for the project, and from the nursing consultant in maternal and child health of the United States Children's Bureau and the district nursing consultant of the U. S. Public Health Service for approval of the educational plan. The plan briefly stated is as follows:

The urgent need for county public health nurses would be met by providing a three-month period of student field training to a selected group of graduate registered nurses who might or might not have had any previous public health

nursing experience or preparation. At the end of the three-months' training the student would be placed in a county nursing service for the period of one year, after which time she would be expected to do at least one quarter of study at a college or university offering an approved program of study in public health nursing. Stipends would be provided for this study period if available.

The purpose of the three-month student training period is: (1) to provide orientation in a generalized family health service, through the teaching of techniques in nursing care and procedure in the home, school, and community (2) to provide instruction in writing and filing nursing records and reports (3) to provide observation and participation in the activities of county and community nursing councils and (4) to give instruction regarding the facilities available for meeting individual and community health needs.

State merit system classifications were adjusted to include this group. During the three-months' training period, the nurse is classified as "public health nurse trainee." During the one-year county experience period she is classified as "county public health nurse—junior B," and with the addition of at least one quarter of university study, she advances to the "county public health nurse—junior A" rating. The county public health nurse senior rating in Iowa requires the completion of a program of study of not less than one academic year of accredited study. The salary scale is graduated to be consistent with the classification rating.

Nurses were selected for the course on the following bases:

1. Age, 21-35.
2. Ability to meet matriculation requirements of a college or university offering accredited courses in public health nursing.
3. Graduation from a school of nursing meeting the requirements of the Iowa Board of Nurse Examiners.
4. Previous experience in nursing service or other employment experience which would contribute to the development of a sense of responsibility.
5. Personal interview.

The nurse trainee was attached to a district health service under the administrative responsibility of the medical director, responsible to the district advisory nurse for training in nursing procedures, and attached to a county public health nursing service for the field experience. Only those counties approved by the University of Minnesota as student training centers were utilized for this special training period. Effort was made to obtain college credit for this training but a university regulation requiring at least one quarter of study prior to field experience prevented. All students entered the course having knowledge of this limitation.

During the fall of 1941 the nursing staff of the state office and the district advisory nurses had participated in the preparation of a manual to be used for university field students. This manual proved to be adequate for the training of this special group with very few changes.

The plan of instruction and experience provided for the group of five trainees who entered the course in January and February, 1942 is as follows:

Field Experience: A total of three months, or approximately 572 hours in eight-hour days.

Section I. Conferences

A. Special lectures by directors of the divisions of the State Health Department (vital statistics, tuberculosis, maternal and child health, nutrition, cancer, communicable diseases, public relations, sanitation and rural public health.)..... 45 hours

At the request of division directors the following outline was prepared to assist them in planning the content of the separate lectures.

1. Brief history of the development of the special field. What problems made necessary this division in a state department?
2. Objectives of the division.
3. Personnel.
 - a. Type—professional, clerical, etc.
 - b. Duties.
4. Functions of the division.
5. What is the relationship of the division to the total public health program in the state?
6. How the public health nurse may contribute to the program and to the division.
 - a. What the nurse may expect from the division.
 - b. What the division may expect from the nurse.
7. Resources of divisions available for use in district and county.
 - a. Films
 - Biologics
 - Literature
 - Consultations
 - b. What use can the nurse make of these?

B. Conferences with district health officer	3 hours
C. Conferences with educational adviser and supervising nurse.....	16 hours
D. Conferences with county public health nurse.....	25 hours
E. Conferences with public health engineer	2 hours

Section II. Observation

A. With health officer in field and office	8 hours
B. With public health nurses—home visits, clinics and school work.....	65 hours
C. With public health engineer—public health sanitary problems and projects in the control of milk, water, food handling, sewage disposal, and home, school and industrial sanitation	8 hours

Section III. Practice (under supervision)

A. Public health nursing visits, clinics, conferences and school health work	200 hours
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Section IV. Studies and Surveys

A. Survey of entire county to learn techniques for collecting information

needed by a public health nurse in entering new territories 17 hours

B. Analysis of records, reports, and assigned reading 31 hours

C. Study of special field problems.. 33 hours

Section V.

A. Meetings and travel.....121 hours

Required Written Work: In addition to field experience, the following written work must be completed by the end of the second month.

A. Survey of county.

B. Daily work sheets including time analysis.

C. Daily time sheets.

D. Daily work sheets to be summarized weekly on observation form.

E. Time sheets to be summarized according to each service at end of trainee period.

F. Regular monthly report.

G. Weekly narrative report.

H. Narrative report in detail on one day's visiting in the field.

I. One other project which should be chosen by the district advisory nurse and the county public health nurse according to the need and interest of the individual student. The project usually chosen has been that of teaching a Red Cross home nursing class.

The third month is spent entirely in independent and supervised practice.

Continuous educational experience is planned for the student after she has been placed in a county service. This will include, in addition to close supervisory guidance on the part of the district advisory nurse, a full day of guidance on the part of each of the consultant nurses—for tuberculosis, venereal disease, maternal and child health, orthopedic and dental programs, as well as the nutritionist in the State Depart-

ment of Health. This day's guidance will include one half day of home visits and one half day of interpretation of the specialized service in relation to these home visits. Participation in planned staff meetings is also a part of this follow-up training.

While it is too early to estimate the results of this training period, some observations can be indicated. Of the five students entering the course four have been placed in county nursing services. The fifth nurse decided she would like to do her quarter of university study before beginning service and was permitted to do so.

Weekly narratives coming into the state office show comprehension of public health nursing services. The advisory nurses who have this group employed in their counties, are enthusiastic in their praise of progress made.

One of the drawbacks is the nurses' feeling of their lack of educational preparation. They are anxious for the time when they can do further study.

The group of four nurses completing the training, together with Iowa's public health nurse stipend group attending the University of Minnesota, served to fill all but one of the existing county vacancies. This included eight new counties adopting the service during the last four months of the fiscal year.

Presented before the N.O.P.H.N. Round Table on Education of the Public Health Nurse in the Emergency, Biennial Convention, Chicago, Illinois, May 20, 1942.

School Nurse Recruits Student Nurses

By THELMA I. SCRATCH, R.N.

THE SCHOOL NURSE is in a strategic position to assist with student nurse recruitment. She is working closely with the potential student. She has entree into the home where she may confer with the parents and answer questions concerning nursing as a career for their daughter. She has the best of opportunities to keep the school personnel—teachers and vocational guidance directors—informed about nursing needs and requirements for entrance into schools of nursing.

A great majority of student nurses enter schools of nursing directly after graduation from high school. During these years the student sees the nurse and what she does by way of health teaching in the school. By her very presence, she is a constant reminder of nursing as a career. Her appearance should always be the best possible, for in these days of multiplicity of uniforms we are aware of the interest created by a trim, attractive uniform. The nurse in uniform should exemplify health in one of its most interesting aspects.

The school nurse who has won the respect of the students will often be asked about nursing as a career. At these times she herself should have the latest information on nursing in order to be of greatest assistance.

She should know the regulations of her own state board of nurse registration. She should know something about the accredited schools of nursing in her own state. She should be familiar with the academic requirements for entrance into the various schools of nursing and courses recommended for the high school student, in order that the student may best prepare herself for nursing education and qualify for entrance into the best

schools of nursing to which she has access.

The nurse may often be of real assistance in guiding a high school student in her reading so that she may know the story of nursing, so well portrayed in such books as *Nurses at Work* by Picture Facts Associates; *Sue Barton—Student Nurse* by Helen Dore Boylston; *Windows on Henry Street* by Lillian D. Wald; *Penny Marsh—Public Health Nurse* by Dorothy Deming; *Health Heroes* published by the Metropolitan Life Insurance Company; *Nurses on Horseback* by Ernest Poole.

The nursing magazines will also interest the high school student. An up-to-date reference file is essential to the well-equipped nurse. Every issue of the official nursing magazines lists new leaflets and pamphlets available to the nurse to keep her informed of the constantly changing picture in the field of nursing. "Professional Nursing and Auxiliary Services," published by The Nursing Information Bureau, has chapters on nursing as a profession, basic educational requirements, the many opportunities open in the various fields of nursing, and other information on auxiliary nursing which is becoming a real part of our program for providing adequate nursing care.

CONFERRING ON CAREERS

"Career conferences" are popular and effective ways of presenting to high school students the important requirements and aspects of various vocations and professions. For three years, Wayne University in Detroit has sponsored such a conference for the high school seniors in Detroit. Dozens of occupations are listed and sent out to the various high

schools for students to consider and indicate their individual interests. The University then obtains speakers from each of these occupations who will come before the students to present details of the various occupations and answer student questions. Special meeting places and appointments are designated for each individual speaker on printed programs which are given to the students so that they can arrange to visit as many conferences as possible. Hundreds of high school students have been approached in this way with time and travel saved for both speakers and students. The school nurses in many schools directed the students to the nursing conference at which five nurses from various fields of nursing talked to approximately 200 students.

In preparation for these nursing conferences, school art departments have sometimes made posters portraying nursing, sewing classes have dressed dolls to depict outstanding characters in nursing. Many attractive displays have been made from these to lead up to "career conference" day when nursing takes its place with the other professions.

The school nurse may also be the one to introduce the home nursing class into the curriculum. This is an excellent facility for directing the thinking of high school students into the consideration of nursing as a career. In one Detroit high school a nursing club has been one of the popular extracurricular activities open to students. Its activities have been directed by the same nurse for several years and its membership has numbered around 50 every year since its inception.

INFORMING THE PARENTS

In her home visits the nurse is the best interpreter of nursing education to parents who might question the choice of this career by their own daughters. In the minds of too many people still lurks the old outworn picture of nurse's train-

ing as it was carried on years ago. They think only in terms of the scrubbing and cleaning that students were reputed to have done and have not been brought up to date on the truly educational experience which is nursing today. The well-informed nurse can answer this question in the minds of many parents—what place can there be for the additional number of students entering nursing now in future days when the emergency has passed and we return to peaceful living. It can well be pointed out that before we entered the war, a survey showed that there were 30,000 unfilled nursing positions in this country; that until all our counties have public health nursing services available to all their residents, American health is being improperly guarded; that in public health nursing and industrial nursing, vast new fields will be opened to the well-prepared graduate nurse; that many more nurses will be needed at home in the hundreds of local hospitals which have been expanding their bed capacities (many with federal funds) to accommodate the increase of patients entering because of the rapidly growing hospital insurance plans—to name only one reason; and that in the postwar plans for rehabilitation of the war-torn lands, America will take the lead in rebuilding health as well as homes as she feeds and clothes those ravaged by war. All of these tremendous jobs will take the best nurses that we can prepare now in our schools of nursing. And today, as these builders of tomorrow are learning their profession, they are helping to do the nursing required in our civilian hospitals, so that graduates may be freed for the job which has nursing priority now—the job of nursing our soldiers and sailors.

In her contacts with school principals, teachers, and guidance personnel in the school, the nurse has an excellent opportunity to keep before them the constantly changing picture of nursing, its needs, its requirements, and its oppor-

tunities. She can best interpret the nursing profession to those who are providing the background and foundation upon which nursing education will build later. Every opportunity should be seized to publicize nursing in the state and local education bulletins, the editors of which have proven themselves to be most cooperative in publishing materials submitted by the nursing group.

NURSE'S PROFESSIONAL RELATIONSHIPS

It is advisable at this time that every nurse maintain a close relationship to her professional organization. She should be an active member in her district, state, and national nursing organizations. She will want to attend meetings of nursing groups in order to be aware of the demands being placed on nursing today and informed on the plans being promoted to meet these demands. By so doing she will be ready to lend the greatest possible assistance in her own particular field. Only by unity and concerted effort will nurses play their maximum role in the total war effort.

In areas where local nursing councils for war service are operating, it is strongly urged that school nurses be represented on the subcommittee on student nurse recruitment or that they offer their services in the recruitment program. In the suggestions of the national Committee on Recruitment of Student Nurses, it is urged that every high school as well as every college be visited for the purpose of presenting the subject of nursing to the women students. Certainly the school nurse is the person most able to plan these visits, and in many instances to present the subject herself at a meeting with the senior girls and whenever possible, the junior girls. The latter group still have a year to add

any required classes that have been omitted in their program of studies.

The need for more students is imperative. The large number of school nurses are in key positions to help with this nationwide program of war nursing. The following materials will be helpful in the presentation of nursing to students, to parents, and to educators:

1. Entrance requirements to schools of nursing as set up by your state board of nurse registration.

2. Complete list of accredited schools of nursing in your state, with some information about each school. (If this is not supplied by your state association, it might be well to obtain the school bulletins from each school of nursing in your state. These make an interesting display.)

3. *Facts About Nursing—1942*. (Revision.) The Nursing Information Bureau, 1790 Broadway, New York, N.Y. 25 cents.

4. *Professional Nursing and Auxiliary Services* is a most helpful booklet. The Nursing Information Bureau. 25 cents.

5. *Nursing and How to Prepare for It*. (Revision 1943.) Nursing Information Bureau. Free.

6. *Better Nursing for America*. (1941.) By Beulah Amidon. Order from The Public Affairs Committee, Inc., 30 Rockefeller Plaza, New York. 10 cents.

7. *Become a Nurse—Your Country Needs You*. An attractive colored poster, 14" x 18", published by the U. S. Public Health Service. Obtained from your state nursing council for war service. Free.

8. *War Work with a Future—Nursing*. An illustrated folder which answers many questions about nursing and lists the essentials of a good school of nursing. Inquire of your state nursing council, or send a three-cent stamp to the National Nursing Council for War Service, 1790 Broadway, New York, N.Y.

9. *Professional Nurses Are Needed*. A new pamphlet by the U. S. Office of Education for use in high schools. See also the Office of Education loan kit containing 15-minute recordings on nursing and program suggestions on recruitment for use in connection with the nursing program of the High School Victory Corps.

Gingivitis and Mouth Infections

By CHARLES W. FREEMAN, D.D.S.

THE COMMON infections of the mouth may be divided into three groups: (1) those beginning in the bone at the end of the root of the tooth (2) those occurring at the margin of the gum where it surrounds the tooth (3) infections and lesions of the mouth not associated with the teeth.

Infections at the root end usually occur as a sequel to disease and death of the pulp—nerve—of the tooth, and may be chronic or acute. Chronic infections are usually diagnosed only by radiographs and give few if any local symptoms. X-rays of all teeth, especially for patients with “dead” teeth, crowns, and bridges, should be made at frequent intervals to discover these hidden sources of infection.

Chronic infections of the root may occasionally become acute, and acute infections usually become chronic unless properly treated by root canal therapy or by extraction of the tooth.

In acute root-end infections, the tooth becomes sore, followed by a swelling of the overlying soft tissues, and frequently the face becomes severely swollen. The pain is severe. There is an elevated temperature and a general feeling of malaise. The tooth should not be extracted in this condition, but general supportive treatment is given, and drainage obtained when possible. These acute dental infections may become very serious, depending on the location, the virulence of the infection, and the general resistance of the patient.

Diseases of the gum border are commonly called gingivitis in cases of simple inflammation, and pyorrhea when there are pus pockets about the teeth where the normal attachment between the gum and the tooth has been seriously af-

fected. Many efforts have been made to classify the variations in diseases of the gingivae, but there are so many variables and so many contributing factors that no satisfactory terminology has been adopted.

The gingivae, which include the gum immediately surrounding the tooth, should be a normal healthy pink color, and firmly attached to the tooth. To maintain this healthy condition, it is necessary to have normal function of the teeth, adequate cleanliness, and good bodily health.

In cases of irregular teeth, or where a tooth has been lost and the contiguous teeth drift from the normal position, there is a greater probability of gum disease because normal function is impaired. Either deficient function, or excessive function—such as occurs where a tooth is in malposition and strikes its opponent with too great force—may cause gum and bone changes resulting in extensive periodontal disease.

Lack of proper mouth cleanliness may contribute very materially to disease and infection of the gum border, especially when heavy deposits of calculus occur on the teeth, causing irritation to the gum. With many adults it is impossible to prevent these accretions from forming, no matter how carefully the mouth is cleansed, and consequently it is important that a dentist remove them at regular intervals and polish the tooth surfaces.

Much of the gum disease is due in part at least to systemic disease or metabolic disturbances. Vitamin deficiencies frequently have their early manifestations in the gums. A classic example is scurvy, in which changes in the gum tissue are likely to be the first symptoms noticed.

In mild vitamin C deficiency the gum frequently becomes inflamed and tender, and is less resistant to local trauma or infection.

In the blood dyscrasias the gums often develop early recognizable symptoms, especially in leukemia where often the first call of the patient is to the dentist because the gums are sore. In every case of severe gingivitis for which there is no local cause readily observed, a blood count should be made.

The diabetic patient shows a rather typical gingivitis. A single tooth or several teeth may develop polyp-like granulation tissue in the surrounding gum. The tooth becomes loose, and pus exudes from the crevice. The gums about the remaining teeth may appear nearly normal, but a few months later other teeth show these same symptoms.

The effects on the gum of endocrine disturbances are not well understood, but there is no doubt some gingivitis is due to this influence. A rather typical gingivitis of pregnancy, with a soft spongy overgrowth of the gingivae is often seen.

Not infrequently deep pyorrhea pockets alongside the teeth develop with no apparent local cause and with very little gum inflammation. There is a progressive resorption of the supporting bone, and detachment of the soft tissues from the cementum of the teeth. Pus is present in quantity in these pockets and no local treatment is effective in controlling the process, which usually ends in the loss of many or all of the teeth. This is undoubtedly due to a systemic rather than a local cause, but so far the etiology has not been discovered.

In many types of gingivitis there is found to be an abundance of Vincent's organisms, but they are probably incidental to a gum disorder due to some other actual causative factor. Vincent's infection (trench mouth) of the gingival tissues is fairly common, apparently especially so in wartime, or in any situation when large numbers of people come

together under new living conditions.

It has been known for years that there are at least two microorganisms—the Vincent's bacillus and the Vincent's spirochete—working together which are responsible for the bacterial phase of this disease. They grow only in an environment free of oxygen. In true cases of Vincent's infection or trench mouth, microscopic examination of smears will show excessive numbers of these bacilli and spirochetes. Since a few of these organisms can be found in healthy mouths, a diagnosis on microscopic findings alone is not justified. Clinical symptoms are rather typical in active Vincent's infection and the diagnosis is not often uncertain. An important fact to remember is that often a predisposing cause, such as vitamin deficiency, dyscrasia, or a dermatological lesion in the mouth, may be significant.

Partially erupted wisdom teeth often prove to be the site of the first infection with Vincent's organism, and a complete cure is frequently impossible until these offending teeth have been removed.

The treatment of Vincent's infection of the mouth was described in an article by Dr. Harry Lyons, in *PUBLIC HEALTH NURSING*, May 1942.

There are other lesions and infections which occur less frequently about the mouth tissues, but those most commonly seen and most significant because of their wide distribution are those mentioned.

Altogether the problem of maintaining healthy mouth tissues is a difficult one. The fullest co-operation between patient and dentist is required and frequently a medical consultation is necessary. The prevention of these disorders by adequate diet, proper mouth hygiene, and maintenance of normal tooth function should be possible if all health agencies co-operate in a program of health education for all the people.

This article is a contribution of the Committee on Public Health and Education of the American Dental Association.

Streamlining Nursing Education

THIS STATEMENT on accelerated programs in nursing education recently approved by the Health and Medical Committee of the Office of Defense Health and Welfare Services, upon the recommendation of its Subcommittees on Nursing and Hospitals, is of importance to the whole nursing profession. It has been sent to all accredited schools of nursing and to the superintendents of the hospitals to which they are attached. The statement together with an explanatory letter by the chairman of the Subcommittee on Nursing are here given in full.

TO DIRECTORS OF HOSPITALS
TO DIRECTORS OF SCHOOLS OF NURSING:

The National League of Nursing Education has sent to you a bulletin, "Nursing Education in War Time," dated November 19, 1942, which contains suggestions for three different types of accelerated programs in nursing education.

Since that bulletin was prepared, the Health and Medical Committee of the Office of Defense Health and Welfare Services, at its meeting on November 18, approved the attached suggestions containing additional recommendations regarding acceleration. These recommendations were made because of the critical situation in nursing. As you know, the requirements of the Army and Navy are increasing monthly. Reports are coming in daily relative to the deficiency in nursing service in general hospitals, especially in target areas where minimum civilian needs seem to be jeopardized.

This total situation was reviewed at a joint meeting of the Subcommittee on Nursing and the Subcommittee on Hospitals held November 17, at which the executive committee of the National Nursing Council for War Service, representatives of the American Red Cross, and the Government nursing services were present. It was recognized that the acceleration of basic nursing programs is one important means of meeting the situation. However, it was also recognized that no one plan for acceleration can be suggested for all of the schools of the country because of variations in local situations, resources, state laws, etc.

The attached plans are sent to you with the urgent request that you begin immediately whatever type of acceleration can be properly undertaken with your present students, and that you make the greatest possible effort to adjust your school program both for the students now in the school and for prospective classes.

The bulletin of the National League of Nursing Education contains suggestions for three different types of accelerated programs, one for 30 months, one for 28 months, and one for 24 months. While the 24-month program was originally planned for mature college graduates with the purpose of preparing them to graduate at the end of 24 months, it is suggested that the same arrangement could be used as a guide by schools offering a three-year course for the less well prepared student so that the instructional program could be concentrated into a 24 months' period and the third year freed for supervised practice. The National League of Nursing Education suggests that if this plan is followed, a definite effort should be made to assign students in the third year to services that will round out their clinical experience and that such experience be made as educational as possible.

As you develop an accelerated program, you may count upon the National League of Nursing Education to assist you with advice and additional information.

Such streamlining of nursing education is considered a war necessity and follows plans for acceleration carried out in other educational fields. The Government urges your careful consideration of these plans and your application of them to your school of nursing at the earliest possible moment.

Sincerely yours,

MARION G. HOWELL, R.N., *Chairman*
Subcommittee on Nursing
Health and Medical Committee
Office of Defense Health and Welfare Services
Washington, D.C.

ACCELERATION OF THE EDUCATION PROGRAM IN SCHOOLS OF NURSING

RECOMMENDATIONS OF THE HEALTH AND
MEDICAL COMMITTEE OF THE OFFICE OF
DEFENSE HEALTH AND WELFARE SERVICES

In order to meet present and anticipated needs for nurses in civilian and military

(Continued on advertising page 13)

Interviewing the Syphilis Patient

By FLORENCE G. BAILEY, R.N.

THE VENEREAL diseases are so personal in character it is essential to reach each infected individual separately for treatment and control of infectiousness. To discover cases is a vast task and to effect treatment followed through is an even vaster. The answers to the problems involved must be stronger than arsenic and of more cumulative value than bismuth. It is only recently that the hushed whisper has been replaced by a normal voice tone in dealing with these questions and it is almost of purely current practice that nonprofessional eyes and ears have been admitted to the scene. Because the roots of venereal diseases are deeply imbedded in sex life, syphilis cannot be swept into the category of other communicable diseases in dealing with its interpretation to the patients. It does and must require a special method and technique which are unique. Vital issues are at stake with the patient: loss of self-esteem, fear of losing job, economic distress, fear of treatment and its reactions, resentment toward infector, embarrassment, social stigma and censure among friends, fear of damage to family life—especially loss of respect of marital partner. Some, if not all of these are blended to produce confusion in the mind of the patient who appears for an interview which itself may be a strange and feared experience.

How then should the interview be conducted? By what approach? How free the patient from his fears, how dispel the cloud of ignorance and give clear-eyed understanding? How re-establish for the patient security in his relationships and restore in him a confidence in his future?

The interview should be at least the beginning of an answer to these questions. The first interview establishes a relationship between patient and clinic. It places the clinic as an ally with the patient in his battle against his disease and acquaints him with the resources and assistance which will help him to carry through. It lays the foundation for a hopeful outcome of the issues involved for him. It interprets the disease and the meaning of treatment to the patient.

The immediate purpose, then, especially in the first interview, is to establish between patient and clinic a rapport strengthened to a point where a lasting impression is made and an enduring confidence is developed. The patient must sense a regard for his own welfare in order to produce reciprocal concern to meet the circumstances necessary to recovery. This necessitates in the interviewer above all else the "case work approach" reflecting objectively a kindly encouragement and understanding, as the patient comprehends it. It indicates full acceptance of the patient as an individual and as he wishes to appear. It is recognition and respect for him as a person; as one needing help, tolerance and active consideration of his plight; as one needing assurance that his morals and character are untouched by tinge of criticism, that his personality is not being invaded by prying, by moralistic admonition or by embarrassing implication. He needs to sense that his personality will remain his own and not become dominated by an over-zealous attempt to reform him. If he is given these assurances throughout all the interviewing he meets, all the objectives in regard to him are

within reach, because his own capacity and self-respect are thus enlarged, to shoulder responsibility for his own disease and treatment.

A knowledge of syphilis is indispensable and is the most valuable "tool of trade" the interviewer can possess. She must know whereof she speaks to produce in patient's response an understanding of his disease and its significance to him. She must skilfully question and analyze dates of exposure in relation to the patient's stage of the disease, to determine the probable origin of the infection. Knowledge of legal requirements is important to an adequate interpretation to the patient of his community responsibility to take treatment, and this must be logical and convincing.

Each case requires an individual plan in which the medical instruction emphasis is adapted to the person, stressing positive rather than negative aspects. It is of little or no value to describe the ravages of inadequately treated syphilis to a young robust adolescent to whom it is beyond the pale of comprehension that he will some day reach the advanced age of even 35 years. In reverse, it is of no use to present a bright prospect of cure to an elderly patient in a stage of late cardiovascular involvement. Neither is it sound practice to discuss a possibility of insanity with an already apprehensive antepartum. A nice balance should be achieved in adaptation of scientific material to the case in hand.

When the persuasive approach has reached the patient and his confidence is won he will willingly act toward getting his contacts examined—or if unable to do so, will trust the interviewer to act for him. He will realize his own good fortune in the discovery of his own condition while early enough for treatment to be effective, and from there it is possible to develop his concern for a victim of infection as un-

aware of it as he was. Freedom from blame and emphasis upon unwitting exposure will help him reveal his contacts.

It may be too much to expect of many syphilis patients that they reveal their intimate sex experiences on the first day in clinic. Fears have been confirmed by the examination and the diagnosis, and the shock is sometimes too great for rapid readjustment. But with the healing effect of time plus arsenic he will be better able to discuss those questions which are of social and public health significance. First failures do not close investigation but pave the way to confidence.

Another aspect of interviewing too little stressed is important to consider. That is the adroit avoidance by the interviewer of producing in the patient a confidence relying too much on her personality. If this does occur it may be nearly or altogether impossible to effect transfer either to another worker or to the clinic service as a whole. The worker is especially clever and sensitive who convinces the patient that she and the other clinic personnel are interested in all the patients, that her recognition of him as he wishes to appear is equally shared by the entire service and that this common knowledge includes and maintains the confidential aspects of his problems. This of course is an element in the "case work approach," one most difficult to manage and sometimes lost in the maze of the worker's involvement.

An interview follows in detail, with the principles outlined on the foregoing discussion in mind. The names used are fictitious.

DR. ABEL: Mrs. Enoch, are you busy?

I have a patient for interview who is having her treatment now. Can you see her?

MRS. ENOCH: Yes indeed, may I see her record?

DOCTOR: Here it is. She has been in

the ward the past week, admitted from Gynecology, where she went for what proved to be condylomata of the vulva. Then along came mucocutaneous lesions—dark field positive—the whole picture—secondary lues. The acuteness is subsiding with the three treatments of neo started. The Chief went over her in medical staff conference and now we want her to have her interview. She's had quite a heavy ordeal and is pretty well confused. I did not get very far with her as to contacts—she's been rather unresponsive. I'll go get her while you go through the record.

WORKER: (*Reads history.*)

DOCTOR: (*Brings patient to chair and introduces her.*) Georgianna, this is Mrs. Enoch who will talk things over with you.

WORKER: (*Notifies that patient is 21, an attractive and intelligent-appearing girl, ill at ease.*) You see, Georgianna, the patients here all have an opportunity like this to talk over their sickness and the treatment so that they may have explanations and help with any trouble they may have. First, tell me, what did Dr. Abel say to you about your condition?

PATIENT: (*shy, self-conscious, looking down.*) She said I have syphilis.

WORKER: Yes, so I understand. What does that mean?

PATIENT: Well, I guess it's catching.

WORKER: That is true, "infectious" is the word we use. And what else did Dr. Abel tell you?

PATIENT: She said I need treatment every week.

WORKER: Did she say how long you must have treatment?

PATIENT: Yes, she said a long time, about a year and a half. (*Tears and sobs.*)

WORKER: (*Handing tissues and then gum.*) Here, take these; they'll help a little. I know, Georgianna, it

sounds like a pretty big hard job to you and it is not easy. But you don't have to let it beat you down, for now, with such an early start, you have everything in your favor and a wonderful chance for a cure. Many people do not know about their syphilis until so late that a lot of damage is done by the time they start. It is not that way with you.

PATIENT: (*Stops crying and looks up at worker, brighter but doubtful.*) I can be cured?

WORKER: You certainly can. There is only one "if" which you must take care of in order to be sure about it. That is, if you have the treatment every week, week after week, continually, until the doctors tell you you have had enough. If the treatment becomes interrupted there is less chance for cure.

PATIENT: Oh, I'll come every week if only I'll be cured.

WORKER: I'm sure you feel that way now. But syphilis plays a few mean tricks and I'd like to tell you a little about it. Very soon now all your symptoms will be completely gone and you will feel like a new person. That is the way the treatment acts.

PATIENT: Then wouldn't that be the cure?

WORKER: No indeed, we all wish it did mean that. It means that the medicines are doing good and that you are started on the way to cure. Only the doctors by treating you a long time and by doing special testing and watching, can tell when you are really cured. And meanwhile, if the treatment becomes stopped or irregular, you may become worse off.

PATIENT: (*Following explanation wide-eyed.*) I'll come every week.

WORKER: Now then, let's go back to what you mentioned before, the infectiousness, or how catching syphilis is. What do you think you should do about that?

PATIENT: I suppose you mean I should stay away from everybody?

WORKER: Yes, as to sex relations or any close body contact like kissing or love-making because it is passed from one to another by those means. The folks in your home will be in no danger when you return to them unless you have very close contact with them, as by fondling or kissing. It would be well for your sister and her kiddies to have examinations in case they possibly may have caught the infection before you knew you had it. Would you like for me to see your sister and explain it to her?

PATIENT: She would be pretty mad at me if you did.

WORKER: We here can do that sort of thing so that she may be more ready to understand than to blame you. Shall I try?

PATIENT: All right, but don't let my brother-in-law know about it.

WORKER: If you think best, at least for now. But now as to you again. You see, because syphilis is passed from one to another, it came from someone to you and you may have given it to others, all the while, of course without you or the others knowing that the infectious process was going on. That is why Dr. Abel asked you to tell us the names of those with whom you have been closely intimate so that they can have the same chance as you, to be cured if they are infected.

PATIENT: How do they know if they have it?

WORKER: By examinations and tests. Don't you think they should have a chance to be cured?

PATIENT: Oh yes, but I'll probably not see them.

WORKER: But you are the only one who knows who they are, and if you tried, you could tell them about this and advise them to be examined.

PATIENT: I told the doctor there was a married man. I might see him.

WORKER: Do that. Here is a card which will admit him to the clinic. The first examination is free and he will be asked no questions at that time.

PATIENT: (*Accepts card.*)

WORKER: When did you last have relations with him?

PATIENT: A month ago.

WORKER: And what is his name and address? You see, if we know who he is then we can treat him just as confidentially as we do you.

PATIENT: John ———, 4173 ——— Street.

WORKER: And now, who else might need this examination?

PATIENT: (*Silent, looking away.*)

WORKER: We understand here, Georgianna, about these things. We are not digging into your affairs or trying to decide how good or bad people are. The only reason I'm questioning you is because the health of other people is concerned. They may be infected as you are and it is our responsibility, yours and mine, to give them the chance for examination. It is mine because it is my job to protect health and yours because the infection is in your power.

PATIENT: But no one protected my health.

WORKER: I know it seems that way to you, but think of this—you did not know you were passing the infection to someone else and so whoever gave it to you must not have known it. You see, nobody has a right to blame anybody and it is nobody's fault. Just tell me who the others are and I'll be glad to arrange for their examinations.

PATIENT: But I don't want them to know I gave them anything like this.

WORKER: But it can all be done without giving your name.

PATIENT: (*Distrustfully.*) How?

WORKER: This way—we would go to the boys and tell them that we know

they have been exposed to syphilis and that they may be infected.

PATIENT: (*Interrupting.*) And they would ask who told you.

WORKER: We explain that this information is confidential and that we cannot tell who told us. Then when they come in, if they are found to have syphilis, we ask them with whom they have been and if they mention your name that is in confidence also. Do you see now?

PATIENT: Well if it's that way, it's all right. There was a boy three weeks ago—Jimmy B——. He lives in the 1400 block on —— Street. You'd better see him.

WORKER: I'll do that. And now who else?

PATIENT: Nobody else.

WORKER: Are you sure? Think back three or four or even six months.

PATIENT: So long?

WORKER: Yes, you see, your syphilis began at least three months ago or longer.

PATIENT: Well, there was one about

three and a half months ago. His name is Bill, I don't know his other name. It was a party. I guess you know how those things happen. He lives on the corner of South Fourth Street, I think, and hangs around the pool room. And, that's all. (*With finality.*)

WORKER: All right, Georgianna. And now, do you want to ask me any questions?

PATIENT: About this infectious part, how long is it catching?

WORKER: That depends on how well you get along and also depends on the regularity of the treatment. In two months you'll be on the safe side, provided you continue regularly week after week. Any more questions? Remember we are in the clinic to help you, so if you have trouble come and talk it over with one of us.

PATIENT: Thanks, I will. You know, I was awfully scared to come in here. I thought you would bawl me out.

WORKER: Of course not. Let us know from time to time how you get along.

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Rural Schools Stress Parent Participation

By ESTELLE M. JUNG, R.N.

THE SCHOOL nursing service of Sibley County, Minnesota, which is part of a generalized public health nursing service, features participation of parents and teachers throughout the program. While this idea is not new, our procedure is new to us and it is meeting with more public approval than anything we have done before.

Sibley County's farm families comprise two thirds of its population of 16,500; two towns of over a thousand each and five villages make up the other third. We are 70 miles southwest of Minneapolis and St. Paul, in an excellent farming section.

Our public health nursing service developed from a Red Cross itinerant nursing program to a full-time service in 1941. The program includes maternity, infant, and preschool and school health service, communicable disease control including tuberculosis and work with crippled children—carried on through the Bureau for Crippled Children of the State Department of Social Security, the County Welfare Board, and the local draft board. Although the whole program is well generalized, the school service is looked upon as the pivotal point from which we work, reaching as it does into every home in the community.

TOWN MEETINGS FOR HEALTH

Because we believe there is a close connection between adult participation in a school health program and other health educational efforts, we plan to have each township hold a health meeting as near the beginning of the school year as possible. Our aim is to assemble teachers, school and health board mem-

bers, and as many parents as room can be provided for. We believe that through these meetings many become more familiar with up-to-date health information and are better able to avail themselves of health resources in the community. At the close of a brief, carefully planned program in which representatives of various health groups—professional and nonprofessional—participate, the meeting is opened to discussion. This gives people an opportunity to express themselves freely. They air their grievances and we find it a nice opportunity to gauge trends. They feel better afterward, and we have a chance to explain what they had believed to be faults in the service. It is important that people come to believe in the job we are trying to do.

Before we approach the schools at all about their program, we learn from teachers the nature of their problems and we have their viewpoint on what can be done to solve them. Teachers and parents, directly or indirectly, are drawn into the picture early.

PARENTS ATTEND HEALTH CONFERENCES

Children are given health inspections by the nurse and referred to the family physician for care as needed. Teachers assume responsibility for parent appointments for pupil inspections. Four appointments are made for each hour, about one every fifteen minutes, from 9:00 a. m. to 3:00 p. m., with time adjusted to allow for dovetailing other services. This leaves the nurse some time for an occasional home visit or conference in the afternoon. It also allows a little time while a parent is present, to confer briefly with her on

matters concerning other family members. All children in a family, in whatever grades, are inspected when the parent comes for the inspection of any one child. Since driving to many homes may soon become impossible—some of us even now being almost reduced to bicycles or mules—a plan whereby the parent consultation can be carried on smoothly in the school seems more than ever advisable. It is easier to judge after even a brief conference with a parent in what instances there is need for more concentrated health work in the home. As a consequence, less time is spent in unnecessary or ineffective home follow up. Through the splendid cooperation of school superintendents and teachers we are getting almost complete cooperation in parent attendance at pupil inspection. Here again, as in all other phases of school health, the teacher is the key person.

While third, sixth, and ninth grade pupils, plus first graders who had no summer round-up examination, are given full inspections in the village and city schools, parents of ninth-grade boys and girls are not invited for inspection of their sons and daughters. We have found that children of this age group respond better without parents being present.

Increasing interest seems to be shown in periodic medical examinations, because parents realize that nurse inspections, though sound as far as they go, stop short of dealing with all important factors vital in the conservation of child health.

ANNUAL CHECK ON CORRECTIVE WORK

Health cards of all children in the schools are checked carefully each year for any note indicating that corrective work has not been done or that no improvement is being noted in remediable conditions. Parents of this group of children are invited for conferences after the nurse has assured herself through the

teacher and pupil that some condition may still need attention. About five percent of these invited parents fail to appear. Home calls are then made to these children.

Every child is given a card which serves as an admission to any dental office in the county for an examination, provided he is accompanied by an adult family member. The same card is used for the dentist's report on the examination and the repair work done for the child. The pupil then returns the card to the teacher who transfers data from it onto the school health record.

Following the suggestion of the Minnesota Department of Health, no comments are made by the nurse on nose or throat conditions except in the light of reported symptoms. In fact, all referrals for medical care are viewed in connection with the history given.

The county welfare board works closely with us, and special committees of that board consider the problems of young members of indigent families. Thus it has become possible to arrange for corrective work, dental or medical, in a good percentage of cases. Emphasis is placed upon those cases where preventive work is possible. The local chapter of the Red Cross assists with correction of defects for children who are members of families with a borderline economic status.

Each teacher is interviewed both before and after her pupils are inspected. Thus, she is given a chance to refer for special attention any pupil in whom first observation has revealed some abnormality of appearance or behavior. After the inspection she is given a report on results, and if necessary, she helps with a plan for the child.

The importance of smallpox and diphtheria protection is emphasized at inspection time, not only for the school children but also for those in the family of preschool age. Of the 765 children given one or the other—or both—

types of immunization in 1941, over a fourth were preschool children.

In the rural communities pupils in each school are given full inspections by the nurse every third year. If the parent cannot be present, another adult member of the family is asked to substitute. All pupils in a rural school, regardless of grade, are inspected if the school is on the full inspection list for the year. Teachers and school board clerks are notified in advance, and one member of the board of health is invited to be present to watch the procedure. This provides a good opportunity for discussion of sanitation, drinking water, and handwashing equipment supplies, and promotes a better understanding of available health facilities in the county.

The other two schools in each rural group of three are visited as necessary for inspection of new pupils and help

to the teacher with special needs of pupils, and with sanitation and other problems. For special inspections following parent consultations in rural districts it is usually less time-consuming to make home calls while in the community than to return there later for two or three conference appointments.

Health records of pupils who move are transferred at the same time as the school report cards. This plan provides a continuous health record for the pupil, and it enables the school and health workers to see the picture as a whole. Health records remain in the school with the teacher, so that her observations as well as those of the nurse, the physician, and the dentist, may be noted.

Our program is incomplete, even for a one-nurse service, but we believe we are building along sound lines in placing our emphasis on active participation of parents and teachers.

NURSE PLACEMENT SERVICE



announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom consent to publish these has been secured in each case from both nurse and employer.

PLACEMENTS

- *Helen Chesley Peck, director, Visiting Nurse League, Fort Wayne, Ind.
- *Emma Belle Crichton, supervising nurse, Lorain County District Health Department, Oberlin, Ohio.
- *Anna Marie Engels, public health nursing instructor, Touro Infirmary, New Orleans, La.
- *Clio Idell Linville, itinerant nurse, American

*Red Cross, Pacific Area, San Francisco, Calif.

Rozalia Kish, industrial nurse, Union Special Machine Company, Chicago, Ill.

Mrs. Edwina Atherton Rubinstein, industrial nurse, Central Scientific Company, Chicago, Ill.

*Ethel Vida Swanson, school nurse, public schools, Jacksonville, Ill.

*Retta Gasteyer, school nurse, Bloomington Schools, Bloomington, Ill.

Agnes Belle Smith, school nurse, County of Shoshone, Wallace, Idaho.

ASSISTED PLACEMENTS

Helen C. Brennan, health teaching advisor and executive secretary, Montgomery County Tuberculosis and Public Health Association, Amsterdam, N.Y.

*The N.O.P.H.N. files show that this nurse is a 1942 member.

Community Agencies Exchange Consultants

A PLAN was initiated in February 1940 whereby the Family Society of Rochester and the Visiting Nurse Association would exchange consultative services. The Visiting Nurse Association would lend its nutritionist for an hour a week to discuss with the staff of the Family Society problems in diet and budgeting, and the Family Society in turn would lend one of its staff members to the V.N.A. to discuss the mental hygiene implications in its cases. This exchange of services was fostered by the fact that the two organizations had some board members in common who recognized the need of each agency for the services of the other.

In planning the family agency's service to the Visiting Nurse Association, our general aims were to help the nurse recognize symptoms of social maladjustment; to help her develop some understanding of the meaning of the patient's attitudes and behavior in terms of his earlier experience and relationships within his family group; and to increase her understanding of the function of other social agencies in the community and how to use them to the mutual advantage of both nurse and social worker. The nurse is in a strategic position to recognize social problems before they become too critical and to bring to the family some interpretation of the services offered by social agencies, while the problem is in a preventive stage.

Since the consultant's time was limited to one hour a week, it seemed that in the beginning the most helpful approach might be through the individual conference method. As a nurse discovered social problems developing within a family situation, she would bring this case into conference with the consultant. As might be expected, the problems recognized by the nurses were

similar to those present in the case load of any family agency—problems of family relationships, old age, and so on, as well as those relating more specifically to the medical situation, such as the attitude of the patient or his family toward his illness. In discussing these problems, consideration would first be given to what other social agencies were active, or what indications there were of need for referral to a cooperating agency equipped to treat the major social problems. At this point case conferences with other social agencies were frequently initiated in order to discuss the implications of both the medical and the social findings. Through these discussions, too, an attempt was made to clarify with the nurse the attitudes of the patient and his family—what meaning the patient's behavior might have and how she could best meet it in her contacts in the home; to help her recognize in what areas she could be helpful and where it seemed that little could be accomplished.

Through the discussion of individual cases, it was noted that specific interests and needs frequently arose which could best be met through group discussion. The nursing staff was divided, accordingly, into four separate groups, each of which met twice with the mental hygiene consultant. In the first meeting some of the techniques of interviewing were discussed; in the second meeting the function of the Family Society and its relationship with other social agencies in the community was discussed.

Through the fall and winter months it is customary in this Visiting Nurse Association for the staff to divide into study groups of eight to ten people each, meeting for one hour in alternate weeks for a period of fourteen weeks. The mental-hygiene group, led by the Family Society consultant, discussed "Emotional

Factors in Illness," which included: (1) the emotional development of the normal person in health (2) the emotional factors in illness in general (3) chronic invalidism in young people (4) emotional factors in pregnancy (5) emotional factors in tuberculosis (6) problems of old age (7) general review and summary.

Another way in which the services of the Family Society were extended to the Visiting Nurse Association was by inviting students in public health nursing to visit the Family Society for a period of three half days to study the function of a case-work agency. During this period several cases were discussed, illustrating the intake policies and procedures in a family agency, the philosophy of relief-giving, family relationships, and coöperation among social agencies in the community. The students were also invited to participate in a staff conference with the consulting psychiatrist to discuss the interrelationship between medical and social factors in the adjustment of an individual client.

This exchange of consultative services has been conducive to a growth of mutual understanding and further coöperation between the two agencies. To the Family Society has come an increased appreciation of the work of the visiting nurse and the part she plays in the patient's emotional as well as his physical adjustment. From the statistics of the Family Society we find that during the year 1939 and the first two months of 1940 there were no cases referred from the Visiting Nurse Association, whereas during the period of March 1, 1940, to March 1, 1941, there were 15 cases referred. The variety of problems present in these cases reflects the nurses' skill in recognizing social problems, their increased understanding of the case-work services of the family agency, and their ability to interpret these services to the family.

DOROTHY B. SHAW

*Case Worker, Family Society
Rochester, New York*

Reprinted from *Highlights*, Family Welfare Association of America.

PATRICIA LEARNS INFANT CARE

PATRICIA was three, the queen of her universe. However, she soon had to make room in her little world for a new brother. We wanted this all to be done with love and understanding, not hurts and jealousies. Shortly before the expected event, we bought a washable baby doll that sleeps and drinks. Patricia's daddy made a little crib just like the one we had for our baby, and I made a layette for her doll consisting of most of the things that we had for our baby. She was thrilled with it all, and soon

learned a good deal about infant care. When my baby had a bath, hers had one too; when my baby ate, hers ate too. Of course this didn't last forever, but it took most of her time during those weeks when so many adjustments had to be made. It worked beautifully, and even though she doesn't spend all of her time with her baby now, she understands why it takes so much of my time to care for my baby.

—Mrs. R. B., Kansas, *Parents' Magazine*
July 1940, p. 32.

Recommended Hours for Maximum War Output

LABOR AND management in general have widely accepted the statement of policy on hours of work for maximum war production as recommended by eight Government agencies—the Labor Department, the War and Navy Departments, Maritime Commission, Public Health Service, Commerce Department, War Manpower Commission, and War Production Board. The four major standards are briefly:

1. For wartime production the 8-hour day and 48-hour week approximate the best working schedule for sustained efficiency in most industrial operations.

2. One scheduled day of rest for the individual, approximately every 7, should be a universal and invariable rule.

3. A 30-minute meal period is desirable.

4. Vacations are conducive to sustained production, and should be spread over the longest possible period.

The recommendation in no way affects the Wage-Hour Act's provision requiring time and one-half pay for all overtime work after 40 hours a week.

The chief effect of the new policy statement on hours should be to reduce excessive working hours per week per worker, which cannot be sustained without impairing the health and efficiency of workers and reducing the flow of production.

Large overtime offers are being used in some instances to pirate workers from other war plants.

One and one-half million war workers now are working over 48 hours a week, according to the Labor Department.

The policy is issued as a guide "to governmental establishments, to field representatives of procurement agencies, and to contractors working on war production."

The statement follows:

In view of the wide discrepancy in labor policy on hours of work among establishments—both private and governmental—working on war production, and in order to secure observance of those standards which experience shows are best for sustained maximum output, the following statement of policy is issued as a guide to Government establishments, to field representatives of procurement agencies, and to contractors working on war production.

Nothing herein contained in any way diminishes the urgency of securing round-the-clock, 7-day-week operation of plants and tools. The primary reason for this statement of policy is to secure increased production, by calling attention to certain practices that have been found to increase the efficiency of the human factor in production.

1. *Weekly day of rest.*

One scheduled day of rest for the individual, approximately every 7 days, should be a universal and invariable rule. The 7-day work-week for individuals is injurious to health, to production, and to morale. It slows down production because of the cumulative effects of fatigue, when not broken by a period of rest and relaxation, and it leads to increased absenteeism. Only in extreme emergencies and for a limited period of time should workers or supervisors forego the weekly day of rest.

2. *Meal periods.*

A 30-minute meal period in midshift is desirable for men and women from the standpoint of the worker's health and from the standpoint of productivity. In occupations that involve contact with poisonous substances workers must have time to wash before eating, as an elementary health precaution.

3. *Daily and weekly hours.*

Daily and weekly hours of employees in war production plants should be reexamined to assure those schedules which will maintain maximum output over a long war period. Hours now worked in some plants are in excess of those which can be sustained without impairing the health and efficiency of workers and reducing the flow of production.

When daily and weekly hours are too long the rate of production tends, after a period, to decrease, and the extra hours add little or

(Continued on advertising page 15)

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

ORTHOPEDIC SCHOLARSHIP AWARDS

THE JOINT Committee on Orthopedic Scholarships has awarded seven scholarships to public health nurses for an approved program of study in physical therapy:

Enid Bailey, formerly on the staff of the Nevada State Department of Public Welfare, Maternity and Child Health Division.

Carolyn Bowen, formerly generalized supervisor on the staff of the Visiting Nurse Association of Providence, R. I.

Dorothy Ailene Browning, now orthopedic supervisor with the Visiting Nurse Association of Brooklyn, N. Y.

Elizabeth M. Carper, now assistant supervisor on the staff of the Visiting Nurse Society of Philadelphia, Pa.

Priscilla Alden Dean, formerly on the staff of the Community Health Association of Boston, Mass.

Louise Hayward, formerly supervisor in the Barry County Health Department, W. K. Kellogg Foundation, Battle Creek, Mich.

Esther E. Snell, now nurse and health education instructor at the State Teachers College, Indiana, Pa.

The Joint Committee has also awarded a scholarship for an approved program of study in public health nursing to Vera Joslyn who is now orthopedic field nurse with the Visiting Nurse Association of Rockford, Ill.

NEWLY APPROVED

THE PROGRAM of study in public health nursing at the University of Colorado, Boulder, Colorado, was approved by the Committee on Accreditation of the N.O.P.H.N. at its December meeting. The program is under the

direction of Ann M. Hellner, associate professor of Public Health Nursing.

N.O.P.H.N. GOES TRAVELLING

Public Health Nursing Organization of Eastchester, Inc., Tuckahoe, N. Y., November 27 — Mrs. Edith Wensley, new secretary of the Board and Committee Members' Section, visited the director, Marguerite Prindiville, to see how that agency conducts its excellent and productive publicity program. . . . **Visiting Nurse Association of New Haven, Conn.,** November 30-December 1—Mrs. Wensley observed volunteers in action. . . . **New York City League of Nursing Education, New York, N. Y.,** December 2—Dr. Philip Stimson, assisted by Mary M. Macdonald, assistant consultant in orthopedic nursing, gave a demonstration of the Kenny Method at the Nurses' Home of New York Hospital. . . . **Lower West Side Health Center of the New York City Department of Health, New York, N. Y.,** December 3—Mary M. Macdonald demonstrated the nursing aspects of the Kenny Method. This was attended by 225 nurses from the City Department of Health and Henry Street Visiting Nurse Service, as well as the health officer of the Center. It met with enthusiastic response. . . . **Visiting Nurse Association of Brooklyn, N. Y.,** December 3—Ruth Fisher met with the executives of 48 eastern and southern public health nursing agencies to discuss adjustments due to the war emergency. This same group met at Henry Street on December 4. Executives present reported it the most valuable meeting of the year. . . . **Washington, D. C.,** December 4-5—Ruth Houlton attended

the annual meeting of the Red Cross Advisory Committee on Nursing Service and a meeting of the Joint Committee on Inter-American Nursing. At the latter, it was brought out that 15 American nurses are at present working in the Latin-American countries and an increasing number of Latin Americans are being sent to the United States for further nursing education. Mary J. Alberti who has been appointed nurse-secretary of the Pan-American Sanitary Bureau will act as secretary of the Joint Committee on Inter-American Nursing. . . .

Association for the Aid of Crippled Children, New York, N. Y., December 7—Jessie L. Stevenson gave a half-day consultation service concerning orthopedic records to the Association. . . .

Visiting Nurse Association, Bernardsville, N. J., December 7—Ruth Fisher advised on current problems of the agency. . . . **Community Health Organization, Boston, Mass.,** December 17-18—Mrs. Wensley consulted with the director regarding the guide for the preparation of volunteers, now being prepared by the N.O.P.H.N. Committee on the Preparation and Use of Auxiliary Workers in Public Health Nursing, and in this connection met with a group of Volunteer Nurse's Aides who had already been out in the field.

NEW CARS FOR NURSES

RECENT correspondence between the N.O.P.H.N. and the Office of Price Administration has resulted in a general clarification of the situation in relation to the purchase of new cars by public health nurses. Main OPA offices have been notified from Washington that nurses employed by visiting nurse associations are entitled to priorities for cars and that they can appeal to the state director of OPA if refused certificates by local boards. Assistant General Thomas E. Harris of the OPA office writes as follows:

We are glad to tell you that we have instructed all OPA regional, state and district offices that "visiting nurse" as used in paragraph (a) of Section 702 of the Automobile Rationing Regulations includes a nurse employed by a visiting nurse association or a public health nursing association.

We suggest that if such visiting nurses are denied certificates by their local boards they appeal to the state director under the uniform appeals procedure recently instituted.

Help for military families: By the fall of 1942, some 25 states and Hawaii were receiving U. S. Children's Bureau funds for provision of obstetric and pediatric medical and hospital care for the families of men in military service. A total of \$308,000 has been allotted for immediate needs. Expansion of the program in these and other states is dependent upon the appropriation of additional funds by Congress. Queried as to whether nonofficial nursing agencies can be reimbursed from these funds for maternity service to wives of men in service where other facilities are not available, Dr. Martha M. Eliot—associate chief, U. S. Children's Bureau—in a letter to the N.O.P.H.N. says:

"In a several-page memorandum to state health agencies last week on the subject of medical and hospital care programs for the wives and children of men in military service, the following recommendation was made by the Children's Bureau: Nursing assistance at home deliveries may also be purchased on a case basis when not available as a part of the regular public health nursing services."

Dr. Eliot further draws attention to a recent Children's Bureau communication to all state health officers, state maternal and child health directors and state directors of public health nursing, relating to the Bureau's policy on home care of maternity cases:

"As a result of this emergency situation in many parts of the country it is urged that in all communities where there are public health nurses employed by official health agencies that as a matter of routine policy the nursing service include postpartum bedside nursing care to women who are delivered at home or who are discharged from the hospital early in the postpartum period, and where possible nursing assistance be made available at home deliveries. Where this type of nursing service can only be made available from nonofficial nursing agencies the Children's Bureau will consider for approval plans which request the use of maternal and child health funds for purchasing delivery or postpartum bedside nursing service."

Reviews and Book Notes

MENTAL HYGIENE FOR COMMUNITY NURSING

By Eric Kent Clarke, M.D. 262 pp. The University of Minnesota Press, Minneapolis, 1942. \$3.50.

This book "attempts to review a cross section of the [mental and emotional] problems that a community nurse encounters and to offer an interpretation of what may lie behind these maladjustments." Its aim is "to enable the community nurse to recognize and report the emotionally needy case for study at an early period when treatment can be most effective." The author describes some of the emotional difficulties of the preschool child, the child at school, the handicapped child, the adolescent, the family, and the convalescent and chronic invalid; and devotes a chapter each to the psychoneurotic, the psychotic, and the mentally defective. The style is clear; the language for the most part is nontechnical; and the many case reports are illuminating. The substance, however, varies in thoroughness of treatment—some chapters being more satisfying than others.

The book is a valuable addition to the growing literature on the emotional aspects of nursing. Within the limits set down by the author, the book accomplishes his aims. It does not go far into prevention, nor into the emotional handicaps of so-called normal individuals; neither does it go deeply into the mechanisms at work in mental deviations. How the nurse herself may be helpful, other than by referring the individual to mental hygiene or psychiatric resources, receives little attention. The use she may make of a greater insight into behavior mechanisms in all her relationships is not developed.

In short, the strength of this book lies mainly in the portrayal of persons manifesting many kinds of exaggerated

behavior and the explanation of its significance, together with a summary of psychiatric treatment and its effect.

ELIZABETH G. FOX, R.N.
New Haven, Connecticut

AMBASSADORS IN WHITE

By Charles Morrow Wilson. 372 pp. Henry Holt and Company, New York, 1942. \$3.50.

Mr. Wilson's "Story of American Tropical Medicine" takes us to Latin America which "is still a sick man's society," despite the fact that Brazil established a medical laboratory there seven years before the United States Public Health Service opened its first hygiene laboratory in New York.

Bringing his facts up to March 1942, the author holds the reader spellbound as he shows how medical men from Cuba, Canada, Japan, and the United States have joined forces with native scientists and doctors in an as yet unsuccessful—though by no means fruitless—effort to eradicate leprosy, malaria, filaria, dysentery, dietary disorders, death-dealing snakes, weird superstitions, powerless but popular drugs, as well as all the other leading causes of unhappiness and ill health in our good-neighbor nations.

His depiction of "The crying human needs that exist . . . for more ambassadors in white" is challenging indeed.

BEULAH FRANCE, R.N.
New York, New York

SUPERIOR CHILDREN THROUGH MODERN NUTRITION

By I. Newton Kugelmass, M.D. 332 pp. E. P. Dutton and Company, Inc., New York, 1942. \$3.50.

A pediatrician has written this book for the purpose of helping parents "perfect the growth and development of their infants and children" through the "application of the newer knowledge of nu-

trition." The mental health aspects of feeding have not been neglected. It is written in an easy style, understandable to the layman, and yet it is the kind of thing which will be helpful to public health nurses. The sections which deal with infant feeding are particularly interesting and there is a discussion of food allergy which is noteworthy. Tables of vitamin and mineral values of foods are included.

There is some variance between these values and those given by other writers (who also vary among themselves), emphasizing our need for further work on this subject.

Occasionally, the author differs with himself. For example on page 29 we find the statement "a quart of milk provides about 150 I.U. [of vitamin A];" while on page 34, the author states that "1 pint of milk yields about 1000 vitamin A units." Of the two, the larger value seems more nearly correct.

FLORENCE SCOTT
Minneapolis, Minnesota

**COLLECTED REPRINTS OF THE GRANTEES
OF THE NATIONAL FOUNDATION FOR INFANTILE PARALYSIS. 1941. VOLUME II.**

As described in the title, this book is a compilation of articles on all phases of infantile paralysis. There are reprints on the etiology, probable means of transmission, pathology, serum therapy, and early orthopedic care of the disease. Of special interest to all nurses are Reprint

36, "The Obstetric Experiences of Women Paralyzed by Acute Anterior Poliomyelitis" by Samuel Kleinberg, M.D., and Thomas Horwitz, M.D.; Reprint 43, "The Virus of Poliomyelitis in Stools and Sewage" by John R. Paul, M.D., and James D. Trask, M.D.; Reprint 45, "Relation of Tonsillectomy and of Adenoidectomy to the Incidence of Poliomyelitis" by Alfred E. Fischer, M.D., Maxwell Stillerman, M.D., and Herbert H. Marks, A.B.; Reprint 93, "Flies as Carriers of Poliomyelitis Virus in Urban Epidemics" by Albert B. Sabin and Robert Ward. M.M.

NURSING OF CHILDREN

By Gladys Sellev, Ph.D. 579 pp. W. B. Saunders Company, Philadelphia, fifth edition revised, 1942. \$2.75.

This is the fifth edition of a textbook designed primarily for use in schools of nursing. In its preparation the author has followed the *Curriculum Guide for Schools of Nursing* published by the National League of Nursing Education. Four chapters have been added: The Adolescent, General Nursing Care of Children, Diseases of the Glands, and The Economic Problems of Maintaining Good Nutrition in Infancy and Childhood. The previous edition, entitled *The Child in Nursing*, was particularly noteworthy because of its emphasis on the growth, development, and care of the normal child. This emphasis has not only been retained but heightened in this last edition. H.H.

RECENT PUBLICATIONS AND CURRENT PERIODICALS

GENERAL

PROFESSIONAL RELATIONSHIPS OF THE NURSE.
Helen F. Hansen, R.N. W. B. Saunders Company, Philadelphia, 1942. 382 pp. \$2.75.

This is a textbook with a refreshingly new approach. Especially interesting and helpful are the chapters, "The Nurse and Her Reading" and "The Nurse as a Writer"; the section on professional organizations; and those chapters on various fields of activity open to nurses.

LIFE CONSERVATION SERIES. Available from the Life Conservation Service, John Hancock Mutual Life Insurance Company, Boston, Mass., 1942. Free.

Bauer, W. W., M.D. Headache: A Signal. 14 pp.

Blood, Alice F., Ph.D. What to Eat and Why. Revised. 24 pp.

Caring for the Sick in the Home. Revised. 30 pp.

Healthy Teeth. 12 pp.

Home Care of Communicable Diseases. Revised. 31 pp.
 Smillie, Wilson G., M.D. Guarding Your Family's Health. 30 pp.
 When the Unexpected Happens: First Aid. Revised. 31 pp.

TEXTBOOK OF ANATOMY AND PHYSIOLOGY. Dianna Clifford Kimber, Carolyn E. Gray, R.N., and Caroline E. Stackpole, A.M. The Macmillan Company, New York, eleventh edition revised 1942. 769 pp. \$3.

TEXTBOOK OF ATTENDANT NURSING. Katharine Shepard, R.N., and Charles H. Lawrence, M.D. The Macmillan Company, New York, second edition revised 1942. 419 pp. \$3.

WARTIME

A GUIDE FOR THE ORGANIZATION OF COLLEGIATE SCHOOLS OF NURSING. Prepared by the National Nursing Council for War Service and the Association of Collegiate Schools of Nursing. Available from the Council, 1790 Broadway, New York, 1942. 35 pp. 25c.

This bulletin covers a discussion of the problems relating to the organization of a collegiate school of nursing, the preparation for such organization, control—both financial and educational, the curriculum, the cost of nursing education. At present, all nursing schools are under great pressure to increase the number of professional nurses for military and civilian needs. This is therefore a very timely guide for those institutions who may be considering such a program or for university or college schools of nursing already in existence who are in need of further guidance.

SERIES ON CHILDREN IN WARTIME BY U. S. CHILDREN'S BUREAU. Available from the Superintendent of Documents, Washington, D.C., 1942.

No. 2. A Children's Charter in Wartime. Bureau Publication No. 283. 4 pp. 5c.

No. 3. Standards for Day Care of Children of Working Mothers. Bureau Publication No. 284. 20 pp. 10c.

TWO PAMPHLETS published by the National Society for the Prevention of Blindness, 1790 Broadway, New York, 1942.

A View of Prevention of Blindness in Relation to Public Health by Eleanor Brown Merrill. Publication No. 381. 8 pp. 5c.

War and Eye Injuries by Olga Sitchevska, M.D. Publication No. 380. 8 pp. 5c.

THE RURAL CHILD IN THE WAR EMERGENCY. C. S. Marsh. Available from The Committee on Rural Education, 5835 Kimbark Avenue, Chicago, Ill., 1942. 35 pp. 10c.

FOUR PAMPHLETS prepared by the Women's Bureau, U.S. Department of Labor. Available from the Superintendent of Documents, Washington, D.C., 1942.

"Equal Pay" for Women in War Industries. Bureau Bulletin No. 196. 26 pp. 10c.

Women's Effective War Work Requires Time for Meals and Rest. Special Bulletin No. 5. 4 pp. Free.

Women's Work in the War. Bureau Bulletin No. 193. 9 pp. 5c.

Your Questions as to Women in War Industries. Bureau Bulletin No. 194. 10 pp. 5c.

VOLUNTEERS IN CHILD CARE. Prepared by the Office of Civilian Defense with the cooperation of the U.S. Children's Bureau and the Office of Defense Health and Welfare Services. Superintendent of Documents, Washington, D.C., 1942. 12 pp. 5c.

FOR OUR CHILDREN IN WARTIME. A program of state action adopted by the Children's Bureau Commission on Children in Wartime in Consultation with the Office of Defense Health and Welfare Services and the Office of Civilian Defense. Available from the Children's Bureau, U.S. Department of Labor, Washington, D.C., 1942. 3 pp. Free.

FACTS ABOUT NURSING. Prepared by the Nursing Information Bureau of the American Nurses' Association cooperating with the National League of Nursing Education and the National Organization for Public Health Nursing. Available from the Bureau, 1790 Broadway, New York, fifth edition revised 1942. 41 pp. 25c.

A convenient source book, especially in its relation to the nation's total war effort. Supply and distribution of our nursing power are pointed up as are the number of nurses serving in military, other government and voluntary hospitals and agencies; the number of nurses needed; the number of students enrolled in nursing schools; the distribution of federal funds for nursing education; salary ranges; and the number of auxiliary workers in nursing services. Space is provided for insertion of new data as they are released through the magazines of the national nursing, medical, hospital, and health organizations.

ORTHOPEDIC NURSING

ORTHOPEDIC NURSING: Content and Method of the Teaching Program in Schools of Nursing. Carmelita Calderwood. Available from the Joint Orthopedic Nursing Advisory Service, 1790 Broadway, New York, 1942. 64 pp. Single copies free.

PHYSICAL THERAPY IN NURSING CARE. George Knapp Abbott, M.D., Fred B. Moor, M.D., and Kathryn L. Jensen-Nelson, R.N. Review and Herald Publishing Association, Washington, D.C., third edition, 1942. 483 pp. \$4.

Of interest chiefly to instructors in schools of nursing. Its purpose is to present to the student of nursing an understanding of physical agencies. Emphasis is especially directed towards hydrotherapy since this branch of physical therapy is the most versatile and the most generally useful. The most widely publicized hydrotherapeutic procedure at the present time—the Kenny fomentations—are not described nor mentioned.

SOCIAL HYGIENE

SUGGESTIONS FOR ORGANIZING A COMMUNITY SOCIAL HYGIENE PROGRAM. American Social Hygiene Association Publication No. A-433. Available from the Association, 1790 Broadway, New York, 1942. 20 pp. 10c.

THE TREATMENT OF SYPHILIS WITH ARTIFICIAL FEVER COMBINED WITH CHEMOTHERAPY. Walter M. Simpson, M.D., H. Worley Kendell, M.D., and Donald L. Rose, M.D. Supplement No. 16 to *Venereal Disease Information*. Superintendent of Documents, Washington, D.C., 1942. 51 pp. 10c.

A critical review of the results of artificial fever and malarial fever therapy of neurosyphilis.

TUBERCULOSIS

TUBERCULOSIS HOSPITAL AND SANATORIUM DIRECTORY. Compiled by the National Tuberculosis Association, New York, twelfth edition revised 1942. 185 pp. \$1.50.

FACTS THAT TUBERCULOUS PATIENTS SHOULD KNOW. Prepared by the Tuberculosis Subcommittee of the Bronx Tuberculosis and Health Committee of the New York Tuberculosis and Health Association, Inc. Available from the Committee, 226 East Fordham

Road, Bronx, N.Y., 1942. 19 pp. Single copy 10c; \$4 per 100.

NUTRITION

OUTLINE COURSE IN NUTRITION FOR CASE WORKERS. Prepared by the Health and Medical Care Division of the Minneapolis Council of Social Agencies. Available from the Community Health Service of Minneapolis, 404 South Eighth Street, Minneapolis, Minn., 1942. 47 pp. 40c.

TWO INFORMATION BULLETINS compiled by The Technical Committee on Evaluation of Printed Material and the Technical Committee on Evaluation of Motion Pictures of the New York City Nutrition Program. Available from the Program, 125 Worth Street, New York, 1942. 15c.

First Official List of Books, Pamphlets, Posters, Charts, and Periodicals on Food and Nutrition.

First Official List of Motion Pictures on Food and Nutrition.

MATERNITY AND INFANT CARE

HOW TO BATHE AND DRESS BABY: TOLD IN PICTURES. Louise Zabriskie, R.N. Available from the author, 1359 York Avenue, New York, 1942. 25c.

LIFE WITH BABY. Elisabeth Godwin and Milton Fox Martin. Duell, Sloan and Pearce, New York, 1942. 94 pp. \$2.

SERIES OF PAMPHLETS prepared by the New Mexico State Department of Public Health. Two of these, written in Spanish, cover care of the baby and the antepartum patient. State Department of Public Health, Santa Fe, New Mexico. Free in limited quantities. Rural nurses will find this series of interest.

INFANT CARE. U. S. Children's Bureau Publication No. 8. Available from the Superintendent of Documents, Washington, D.C., fourth edition revised 1942. 135 pp. 10c.

NEWS

Highlights on Wartime Nursing

WHAT THE COUNCIL IS DOING

WHETHER OR NOT there shall be a National Nurses' Supply Board under government auspices is a question still unsettled. However, after careful consideration of recent events relating to the whole question of manpower distribution, the National Nursing Council for War Service at its December meeting reaffirmed its earlier recommendation to the Subcommittee on Nursing that such a board be established under the War Manpower Commission. The Subcommittee was requested to develop plans in detail and a tentative budget.

The Kellogg Fund has approved a grant of \$24,000 to the Council to be used for accelerating nursing education programs. Plans are being worked out by a committee for the quick and effective use of this money.

Up to New Years, 7,403 letters had been received in response to the Council's December 7-14 radio campaign to recruit student nurses: 1,198 asked for some kind of scholarship assistance, 6,247 may be eligible for admission to schools of nursing, 60 were college graduate inquiries, and 254 had partial college training.

The *Good Housekeeping* appeal to inactive nurses to return to service resulted in 312 responses up to the end of the year. Of those replying 129 were ready, prepared and referred to hospitals; 69 were married nurses with young children, or pregnant; 71 were referred to state nursing councils for help in problem solving before returning to work; 43 were probably unemployable due to state laws, illness, or other reason.

A joint committee of the National

Nursing Council and the American Hospital Association has been formed to study matters of mutual interest and pressing need. Susan C. Francis, chairman, Sally Johnson, Anna Wolf, Bessie Parker and Lucile Petry will represent the Council on this committee.

The long-anticipated "Manual for State Nursing Councils" has gone to press and will be ready in January for free distribution to a selected list of key persons.

Copies of a new recruitment folder, "War Work with a Future—Nursing," and a leaflet, "Information Concerning Scholarship and Loan Funds Available to Students in Schools of Nursing," were distributed at the end of the year to directors of schools of nursing and others especially concerned with recruitment. These can be secured in quantity at cost.

THE RESURVEY OF GRADUATE NURSES

A NATIONWIDE survey of graduate registered nurses is being undertaken January 1, 1943 by the U. S. Public Health Service at the request of the Subcommittee on Nursing of the Office of Defense Health and Welfare Services. Every effort will be made to obtain an accurate and complete record of the available nurse power of the country.

The questionnaire being sent to nurses for the survey carries this statement by Paul V. McNutt, chairman of the War Manpower Commission: "The nursing shortage is urgent, both at home and on the fighting fronts. Today there is only one place for the graduate registered nurse to be—that is, on active nursing duty. That means all nurses. Whether

(Continued on advertising page 9)

From Far and Near

• Recently elected officers of state organizations for public health nursing are as follows:

Iowa

President—Adah Hershey, Des Moines
Secretary—Norma A. Michaelson, Centerville
Treasurer—Mrs. Gladys Bradley, Sibley

Nebraska

President—Mrs. Elsie Webster, Omaha
First Vice-President—Mrs. Everett Angle, Lincoln
Second Vice-President—Genevieve Brugge-
man, Grand Island
Secretary—Edna Brown, Omaha
Treasurer—Mrs. Murrell Johnson, Lincoln

Washington

President—Grace Watson, Seattle
Second Vice-President—Dorothy Ekholm,
Seattle
Secretary—Olga Goplen, Spokane
Treasurer—Anne E. Carlson, Mount Vernon

• The Merit System of the Pennsylvania Department of Health announces open competitive examinations on February 20 for the following positions in the Bureau of Public Health Nursing at the salary ranges indicated:

Assistant Director—\$3,456 to \$3,600
Supervising Public Health Nurse—\$2,760 to \$3,456
Consultant in Special Field—\$2,760 to \$3,456
Senior Public Health Nurse—\$2,136 to \$2,412
Public Health Nurse—\$1,860 to \$2,136
Public Health Nurse Trainee—\$1,584
Staff Nurse—\$1,584 to \$1,860

Appointments to these positions will be made from lists established from the results of these examinations during the next two years. Nurses are asked to apply now even though they are successfully employed. Application blanks may be secured from the Merit System Office, 207 Blackstone Building, Harrisburg.

• The Board of Civil Service Commissioners of Los Angeles announces an examination for the position of principal public health nurse

in the City Department of Health at a basic salary of \$175 with a monthly bonus of \$20 effective at least until June 30. The local residence requirement has been waived, and applications (which must be accompanied by a fee of \$1.00) may be filed until January 25. The written portion of the examination will be held on February 19 in Los Angeles and other cities as needed. Application forms may be obtained from the Commission, Room 11, City Hall, Los Angeles, California.

Threat of tuberculosis: "As in all past wars, tuberculosis is on the increase," states Dr. Kendall Emerson, managing director of the National Tuberculosis Association. "It has risen alarmingly in Europe and in Asia. So far, in this country, however, preliminary figures for 1942 indicate that tuberculosis deaths will be the lowest on record. But, during the last year, the American people have not been subjected to real wartime conditions. The full impact of the war on the campaign to control tuberculosis will probably be felt during 1943." Tuberculosis associations will stress medical research, expansion of X-ray surveys among industrial workers—particularly young women, full assistance to men rejected from the armed forces because of tuberculosis, cooperation in the health program of the High-School Victory Corps, and a vigorous health education campaign to drive home to individuals the necessity and the ways of maintaining a high resistance to the disease.

Mental Hygiene in 1943: The National Committee for Mental Hygiene, according to its medical director, Dr. George S. Stevenson, announces a seven-point program for 1943 with the following objectives: (1) assurance that the armed forces be composed of mentally healthy men and that the mentally unstable be protected against military duty and conserved for useful civilian work (2) prompt detection and treatment of the mentally ill within the armed forces, both incipient and serious cases (3) rehabilitation of disabled civilian and service men to augment manpower and help individual adjustment (4) protection of civilian services for the mentally defective, unstable or ill (5) maintenance of public morale (6) promotion of competent social, recreational, health, and educational agencies and personnel services to help in the adjustment of persons moving to strange locations (7) strengthening services and adjusting policies to meet the difficult peoples' problems in the postwar world.

(Continued on advertising page 10)

Our Readers Say . . .

NAVY, ARMY, OR PUBLIC HEALTH NURSING?

FOR THE PAST twelve months public health nurses have been faced with a tremendous question—to remain in public health work or enlist in the Army or Navy Nurse Corps? Is it unpatriotic for a nurse specialized in public health to remain in that field when her country is crying for more nurses in the armed forces?

Red Cross veterans of World War I say they wouldn't trade their past experience for years of duty here at home during wartime. They say it's a service one owes to her country; it's an adventure one shouldn't miss regardless of specialization and importance of position held at the moment. I agree heartily with such patriotism, such self-sacrifice, such enthusiasm, but it stands to reason we can't all enlist in the Red Cross and be Army and Navy nurses. One must weigh all aspects of the question on hand before an intelligent, logical answer can be reached.

Public health nursing today is perhaps occupying a more important role than it has hitherto ever occupied. Before December 7, 1941, there were thousands of schools and about 700 counties in the United States without benefit of public health nurses. This sparsity of service was due to many reasons, among which were lack of financial resources, lack of trained personnel on hand, and lack of appreciation of the work which public health nurses are capable of doing. Today, after we have been engaged in war twelve months, many communities which previously had public health nurses have lost them to the military services. The urgency of the situation would be less apparent if these same communities hadn't also been depleted of their medical care. For example, in the state of Minnesota there are already four counties each with a population of over 10,000 without a doctor. Many are without a dentist. Many more have only one doctor and one dentist who endeavor to give adequate care.

I don't mean to imply that public health nurses can do the work of doctors but I do maintain that the responsibility carried by public health nurses has increased ten-fold in this present crisis. Someone—many someones—must look after the health of those families and individuals here at home who are engaged in the important work of keeping our armed forces supplied with food and equipment to fight a winning war. Our infants, children, and students—the adults of tomorrow—deserve

a helping hand along the road to health, happiness, and success. All this is within the scope of the public health nurse if she would but realize her possibilities.

Therefore, shouldn't nurses now in counties, in schools, and still in universities and schools of nursing completing their training think not only twice, but many times before making their final decision between public health nursing and the Army or Navy Nurse Corps. We can't all be public health nurses and we can't all be Army and Navy nurses. They say it takes ten men here at home to keep one soldier fed, clothed, and armed. Public health nursing here at home can't be measured quite as specifically in the present. Its work reaches far into the space of time—into the future of tomorrow.

MARY T. HENNS, R.N.
Red Lake Falls, Minnesota

V.N.A. ADVERTISES SERVICE

I UNDERSTAND that the N.O.P.H.N. Committee on Pay Service would like to know of any agency advertisement in the telephone directory. Here is our ad which we have had for several years, costing \$150 a year. We think that this ad in the yellow pages of the telephone directory is good because it is seen so quickly whereas smaller type is hard to find.

VISITING NURSE ASSOCIATION
GRADUATE REGISTERED NURSES
AVAILABLE BY THE HOUR
IN YOUR NEIGHBORHOOD
HOURS 8:30 A.M. TO 5 P.M.
For further information call
Prospect 3910
2157 Euclid Avenue

ELIZABETH M. FOLCKEMER, R.N.
*Director, The Visiting Nurse
Association of Cleveland, Ohio*

COUNTY SERVICE PREPARES

I WAS GREATLY interested in the article by Miss Jones on "Public Health Nursing in Hawaii at War." We are busy getting ready and her article gives us an idea of some of the situations public health nurses may have to meet here in California.

The public health nurses in the county health department have been teaching over 50 Red Cross home nursing and care of the sick classes since December (1941) on department time. Selected class members are now coming to the health centers to assist in conferences and clinics and will be used to supplement

services of our own staff in the field in the event of need. Red Cross Volunteer Nurse's Aides are also working in the district health nursing centers and are proving most helpful—both in actual assistance and interpreting the health department's program to their community contacts.

At the request of nurses attending the recent Red Cross Disaster Nursing Institute, lectures on "War Injuries and Their Treatment" were given by the chief of the Medical Advisory Committee of the county medical association for all the nurses assigned to casualty stations in the Los Angeles Chapter Area. These same lectures are being repeated for physicians and nurses jointly in various sections of the county.

ANN L. FINCH, R.N.
Alhambra, California

PAT ON THE BACK

MANY THANKS for sending me a copy of the nice review of "The Role of the Teacher in Health Education." I am much interested in the very great contribution to the all-round development of individuals which the public health nurse makes, especially in the guidance aspect of her work, and enjoy very much the group of public health nurses who take my course in personnel work. They are alert to the importance of establishing objective friendly relationships, and of cooperating with teachers in the guidance of boys and girls.

RUTH STRANG
*Teachers College, Columbia University
New York, N.Y.*

P.H.N. FAN MAIL

KINDLY CANCEL my subscription. Your magazine is a weak solution to my problems. It doesn't contain enough "meat."

R.N.
Washington

I WANT YOU to know that a discussion of the articles in PUBLIC HEALTH NURSING is a part of our program at each staff meeting. This assignment is given to a different nurse each month. It helps us in many ways. The nurse presenting this gets practice in speaking from the floor and she becomes keen in bringing to our attention the important articles. It also brings about much discussion; it stimulates interest in the magazine's value and keeps us all familiar with current information.

MARY D. DAVIS, R.N.
*Director, Division of Public Health Nursing,
State Board of Health
Concord, New Hampshire*

WITH SO MANY and so rapid advances and changes taking place in the field of public

health and public health nursing, more and more I find myself turning to our professional journals for information and inspiration. My work with the National Office of the Victorian Order takes me across the country and I am able to see the changes, both good and bad, which war industries and troop concentrations are bringing about in our towns, cities, and even villages. I wish to have my own copies of PUBLIC HEALTH NURSING henceforth and am enclosing a money order for my next year's subscription.

E. A. ELECTA MACLENNAN
Truro, Nova Scotia

I HAVE the clipping you sent calling attention to the item on the School Sanitation Bulletin which is distributed through the Division of Public Health Nursing. If there is any doubt in the minds of any persons regarding how well the official magazine is read, I wish to assure you that even the smallest item is not passed by. We have received requests from all over the United States for copies of this bulletin. I am glad we had a sufficient quantity on hand so we can supply the demand. Even some of the Iowa nurses who had already received the bulletin requested another copy.

EDITH S. COUNTRYMAN, R.N.
*Director, Division of
Public Health Nursing
Iowa State Department of Health*

I HAVE not been employed for two years, because I took a leave of absence to attend school, and then because of illness. I have never appreciated our nursing magazines more! Each month brought so much to keep me abreast of the times: what nurses are thinking and doing on problems of the day, eight-hour duty, social security, new drugs and their actions and uses, problems and plans in visiting nursing and in school nursing—the latter two fields being my particular interest. And best of all, for once I really had time to read every month's articles, not just my usual hurried scanning of the magazine with only time to read one or two articles that seemed most important.

NEVA HARRIS, R.N.
Macedonia, Iowa

HELPING BEGINNERS

I AM WRITING to let you know how much I enjoyed reading the article, "What Can the Industrial Nurse Accomplish?" by Pauline E. Kuehler in the February (1942) PUBLIC HEALTH NURSING magazine. It was through

(Continued on advertising page 19)

Official Directory of Public Health Nurses

Listing those holding executive positions in the Federal Government, in national organizations, and in states and territories, officers of state organizations for public health nursing and public health nursing sections of state nurses' associations, and directors of public health nursing courses

Information as of December 1, 1942, unless otherwise stated.

National Organization for Public Health Nursing, Inc.

President, Marion G. Howell, Frances Payne Bolton School of Nursing, Western Reserve University, 2063 Adelbert Road, Cleveland, Ohio.

General Director, Ruth Houlton, 1790 Broadway, New York, N.Y..

American Red Cross, Nursing Service

(All at American Red Cross, National Headquarters, Washington, D.C.)

National Director, Mary Beard.

Assistant Director, Virginia M. Dunbar.

Assistant Director, Public Health Nursing and Disaster, Mrs. Elsbeth H. Vaughan.

Assistant Director, Enrollment, Gertrude Banfield.

Assistant Director, Red Cross Home Nursing, Olivia T. Petersen.

Assistant Director, Health Education, Lona L. Trott.

Assistant Director, Enrollment, Mrs. Dorothy Conrad.

Assistant to National Director, Enrollment, Annabelle Petersen.

Assistant to National Director, Enrollment, Marie Peterson.

Assistant to National Director, Enrollment, Mrs. Bertha M. Seering.

Assistant to National Director, Enrollment, Mrs. Lavenia Davenport.

Assistant to National Director, Enrollment, Mrs. Ernestine B. Amick.

Assistant to National Director, Enrollment, Mary E. Beam.

Assistant to National Director, Red Cross Home Nursing (Educational Assistant), Anna C. Gring.

Assistant to National Director, Red Cross Home Nursing, Mrs. Mildred Smith Chambers.

(Nurses assigned to other administrative divisions of the Red Cross)

Disaster Service, Director of Nursing, Ella B. Gimmestad.

Volunteer Special Services, Associate Director, Volunteer Nurse's Aide Corps, Ida B. MacDonald.

Welfare Nurse, Mary L. Hawthorne.

Welfare Nurse (Printcraft Building), Mrs. Ida Doyle Coe.

North Atlantic Area

(All to be addressed at American Red Cross, 300 Fourth Avenue, New York, N.Y.)

Director, Mrs. Gertrude Lyons.

Assistant Director, Ruth Addams.

Assistants to the Director:

Red Cross Home Nursing, Mrs. Thelma Bayard.

Marjorie Tucker.

Catherine Nardi.

Nellie Ogilvie.

Pamela Besom.

Lillian MacKinnon.

Enrollment, Edith W. Unruh.

Volunteer Nurse's Aides, Mrs. Marion Juergens.

Consultants:

Iva Torrens—Maine.

Ethel M. Holmes—New Hampshire.

Mrs. Grace Lee—Rhode Island, Massachusetts (Southeast).

Mary A. Donnelly—Connecticut.

Hazel Dudley—Connecticut.

Gertrude Landmesser—Massachusetts (Eastern).

Gertrude A. Cramer—Massachusetts (Western).

Mrs. Charlotte Heilman—New Jersey.

Winifred Erskine—New Jersey, Delaware.

Mildred Gonyeau—New York (Western).

Josephine Beuchat—New York (Central).

Dorcas Bennett—New York (Eastern).

Therese Kerze—New York City and Long Island.

Charlotte Eaton—To be assigned.

Mrs. Sarah Fish Woodworth—Special Consultant, First Service Command.

Eastern Area

(All to be addressed at American Red Cross, 615 North St. Asaph Street, Alexandria, Va.)

Director, Marguerite Wales.

Assistant Director, Virginia B. Ellman.

Assistants to the Director:

Red Cross Home Nursing, Mary E. DeLaskey.

Volunteer Nurse's Aides, Mrs. Bertha Blake Jones.

Mrs. Nellie P. Cuenco.
 Florine Thomason.
 Elsie Witcher.
 Lydia Spooneman.
 Mrs. Naomi L. Gable.
 Eugenia L. Klinefelter.
 Esther Finley.
 Jeanie L. Adkerson.
 Dalya Wildebar.
 Mrs. Juliana Fowle.

Consultants:

Ruth E. Phillips—Pennsylvania (Eastern).
 Jeanette Vroom—Pennsylvania (Central).
 Catherine Colle—Special Consultant in Enrollment, Pennsylvania (Central).
 Mrs. Elizabeth Martin—Pennsylvania (Western).
 Mrs. Edith Tetlock—Maryland, District of Columbia.
 Ella T. Lynch—Virginia.
 Mrs. Ruth J. Frantz—North Carolina.
 Mrs. Kathleen Muse—South Carolina.
 Alice Dugger—Florida, Georgia.
 Katherine Myers—Special Consultant in Nurse's Aides and Enrollment, Florida, Georgia.
 Virginia Stone—West Virginia.
 Theresa Campbell—Kentucky.
 Mrs. Ruth L. Lusk—Tennessee.
 Winifred Bonham—Tennessee (Western).
 Katherine Cameron—Alabama.
 Lydia Reitz—Louisiana.
 Gertrude Dale—Mississippi.
 Mary B. McDevitt—Ohio.
 Irene Bower—Ohio.
 Anna L. Jenkins—Indiana.
 Mrs. Gisella S. Brady—Special Consultant in Home Nursing.
 Mrs. George M. T. Douglas—Special Consultant in Home Nursing.
 Irene Roller—Special Consultant in Home Nursing.
 Christine Cornwell—Special Consultant in Home Nursing.
 Ruth Bean—Special Consultant, Fourth Service Command.

Midwestern Area

(All to be addressed at American Red Cross, 1709 Washington Avenue, St. Louis, Mo.)

Director, Myrtis M. Coltharp.
 Assistant Director, Rebecca Pond.
 Assistant Director, Florence Spaulding.
 Assistants to the Director:
 Catherine McDermott.
 Henrietta Gronlid.
 Ann Magnussen.
 Rosa Schladweiler.
 Enrollment, M. Luella Gardner.
 Nurse's Aides, Mary Alexander.

Consultants:

Edna Peterman—Texas (Central).
 Catherine McCarthy—Texas (Eastern).
 Petronilla Commins—Texas (Western).
 Flora Williams—Texas (Southern).
 Petronilla Commins—New Mexico.
 Catherine McCarthy—Arkansas.
 Rachel Moses—Colorado.

Helen Pittman—Oklahoma.
 Elizabeth McCoy—Montana, Wyoming.
 Elvera Brueggmann—North Dakota, South Dakota.
 Nancy Jane Cummings—Iowa (Eastern).
 Lucile M. Johnson—Iowa (Western).
 Olive Lee—Nebraska.
 Lillian Upham—Michigan (Lower).
 Florence Beseman—Kansas.
 Lucile Musgrove—Missouri.
 Marien Beseman—Missouri (Northern).
 Edith L. Olson—Minnesota.
 Helen Flanagan—Illinois (Northern).
 Mrs. Berenice Gardner—Illinois (Southern).
 Mrs. Ada Crocker—Special Consultant in Enrollment and Nurse's Aides, Illinois.
 Mrs. Helen C. LaMalle—Special Consultant, Seventh Service Command (Enrollment).
 Thelma Munn—Special Consultant, Sixth Service Command (Enrollment).
 Mrs. Ruby Caldwell—Special Consultant in Home Nursing.

Pacific Area

(All to be addressed at American Red Cross, Civic Auditorium, 61 Grove Street, San Francisco, Calif.)

Director, Gladys L. Badger.
 Assistant Director, Edith Olson.
 Assistant Director, Enrollment, Louise L. Baker.
 Assistants to the Director:
 Ruth Ellis.
 Reba Edwards.
 Consultants:
 Margaret Woodruff—Oregon.
 Lois Goodman—Idaho, Utah.
 Katherine Laux—California (Northern), Nevada.
 Mrs. Elizabeth Kulchar—California (Central).
 Katherine Forsythe—California (Southern), Arizona.
 Florence L. Uhl (Nurse's Aides)—Los Angeles County.

National Association of Colored Graduate Nurses, Inc.

President, Mrs. Frances F. Gaines, 649 East 50 Place, Chicago, Ill.
 Executive Secretary, Mabel K. Staupers, 1790 Broadway, New York, N.Y.

U. S. Department of the Interior
Bureau of Indian Affairs

Director of Nursing, Sallie Jeffries, Office of Indian Affairs, Department of the Interior, Washington, D.C.
 Associate Public Health Nursing Consultant, Bertha Tiber, Office of Indian Affairs, Department of the Interior, Washington, D.C.
 Field Nurse Supervisor, Mrs. Helen P. Olmstead, Care of Five Civilized Tribes Indian Agency, Muskogee, Okla.
 Assistant Field Nurse Supervisor, Beulah

Oldfield, Kiowa Indian Agency, Anadarko, Okla.

District Supervisory Nurses:

Mary E. McKay, 218 Federal Office Building, Minneapolis, Minn.

Gertrude F. Hosmer, P.O. Box 527, Albuquerque, N. Mex.

Supervisor of Nurses in Alaska, Mabel L. Morgan, P.O. Box 1751, Juneau, Alaska.

Federal Security Agency

Public Health Service; Public Health Nursing Section, States Relations Division

Principal Nursing Consultant, Pearl McIver, U. S. Public Health Service, Washington, D.C. (Bethesda Station).

Senior Public Health Nursing Consultant Mary J. Dunn, U. S. Public Health Service, Washington, D. C. (Bethesda Station).

Public Health Nursing Consultant, Anna Heisler, U. S. Public Health Service, Washington, D.C. (Bethesda Station).

Public Health Nursing Consultant, Donna Pearce, U. S. Public Health Service, Washington, D.C. (Bethesda Station).

Associate Public Health Nursing Consultant, Olive M. Whitlock, National Institute of Health, Bethesda, Md.

Associate Public Health Nursing Consultant, Henrietta Landau, U. S. Public Health Service, Washington, D.C. (Bethesda Station).

District Public Health Nursing Consultants

Rosalie Peterson, Sub-Treasury Building, 15 Pine Street, New York, N.Y.—Connecticut, Delaware, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont.

Bertha Allwardt, National Institute of Health, Bethesda, Md.—District of Columbia, Maryland, North Carolina, Virginia, West Virginia.

Marion Ferguson, Room 855, U. S. Custom House, 610 Canal Street, Chicago, Ill.—Indiana, Illinois, Kentucky, Michigan, Ohio, Wisconsin.

Helen Bean, Room 1307, Pere Marquette Building, New Orleans, La.—Alabama, Florida, Georgia, Louisiana, Mississippi, New Mexico, South Carolina, Tennessee, Texas.

Mary D. Forbes, 1223 Flood Building, San Francisco, Calif.—Alaska, California, Hawaii, Nevada, Oregon, Washington, Arizona.

Mrs. Florence Callahan, U. S. Public Health Service, San Juan, Puerto Rico—Puerto Rico and Virgin Islands.

Lily Hagerman, 215 West Pershing Road, Kansas City, Mo.—Arkansas, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, Oklahoma.

F. Ruth Kahl, 617 Colorado Building, Denver, Col.—Colorado, Idaho, Montana, Utah, Wyoming.

Lorena Jane Murray, 1604 Smith Young Tower, San Antonio, Tex.—New Mexico and Texas.

U. S. Department of Labor

Children's Bureau, Public Health Nursing Unit

Director of Public Health Nursing, Naomi Deutsch, Children's Bureau, Department of Labor, Washington, D.C.—District of Columbia, Maryland, Virginia, North Carolina.

Regional Public Health Nursing Consultants and Territories

(To be addressed at Children's Bureau, Department of Labor, Washington, D.C.)

Vacancy—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, New York, New Jersey, Pennsylvania, Delaware.

Ruth Heintzelman—Wisconsin, Michigan, Illinois, Indiana, Ohio, Kentucky, West Virginia, Puerto Rico.

Jane Nicholson—North Dakota, South Dakota, Nebraska, Kansas, Oklahoma, Minnesota, Iowa, Missouri, Arkansas.

Ruth Doran—New Mexico, Texas, Louisiana, Mississippi, Alabama, Tennessee, Georgia, South Carolina, Florida.

Alice F. Brackett—Washington, Oregon, California, Utah, Idaho, Nevada, Arizona, Montana, Wyoming, Colorado, Territories of Hawaii and Alaska.

U. S. Veterans' Administration

Veterans' Administration Nursing Service—Superintendent of Nurses, Mrs. Mary A. Hickey, Veterans' Administration, Washington, D.C.

ALABAMA

Section on Public Health Nursing of State Nurses' Association—Chairman, Pearl Barclay, State Department of Public Health, Montgomery. Vice-chairman, Annah Sappington, Opelika.

State Board of Health—Pearl Barclay, Associate Director of Public Health Nursing, Division of Nursing, Bureau of County Health Work, State Department of Public Health, Montgomery.

State Nurses' Association Paid Executive—Mrs. Walter Bragg Smith, 625 South Lawrence Street, Montgomery.

ARIZONA

Section on Public Health Nursing of State Nurses' Association—Chairman, Frieda Olson, Hassayampa Mountain Camp, Prescott. Vice-chairman, Mrs. Sabina Gilbert, Washington School, Prescott. Secretary, Mrs. Elizabeth Poupore, 841 N. Second Avenue, Phoenix.

State Department of Health—Jefferson I. Brown, Director, Division of Public Health Nursing, Phoenix.

ARKANSAS

State Organization for Public Health Nursing—President, Mrs. Clyde K. Barr, 215 West "H" Park Hill, North Little Rock. Secretary, Olive Petillo Miller, County Health Department, Texarkana. Treasurer, Mrs. Jean Quimby, City Health Department, Little Rock.

State Board of Health—Margaret S. Vaughan, Supervisor of Public Health Nursing, Bureau of Local Health Service, Little Rock.

State Nurses' Association Paid Executive—Mrs. Terry Brady Hess, 1614 West 8th Street, Little Rock.

CALIFORNIA

- State Organization for Public Health Nursing**—President, Olivia Hunsinger, P.O. Box 532, Pittsburg. Secretary, Virginia E. Platt, 2340 Clay Street, San Francisco. Treasurer, Phebe Kirby, Court House Annex, Santa Cruz.
- State Department of Health**—Reina Haig, Chief, Public Health Nursing Service, 603 Phelan Building, San Francisco.
- California Tuberculosis Association**—Irene Carlson, 45 Second Street, San Francisco; Beatrice Woodward, 45 Second Street, San Francisco.
- State Nurses' Association Paid Executive**—Shirley C. Titus, 609 Sutter Street at Mason, San Francisco.

COLORADO

- Section on Public Health Nursing of State Nurses' Association**—Chairman, Myona Morrison, 1368 Eudora Street, Denver. Vice-chairman, Mrs. Virginia Adkins, 3145 South Grant Street, Englewood. Secretary, Anabel Perkins, 1255 Dexter Street, Denver.
- State Division of Public Health**—Mary Emberton, Director, Division of Public Health Nursing, 424 State Office Building, Denver.
- Colorado Tuberculosis Association**—Mrs. Louise Gaghagen, 613 Mock Building, Denver.
- State Nurses' Association Paid Executive**—Irene Murchison, 621 Majestic Building, Denver.

CONNECTICUT

- Section on Public Health Nursing of State Nurses' Association**—Chairman, Marion M. Redmond, 570 Howard Avenue, New Haven. Vice-chairman, Amelia M. Meyersieck, 40 Sanford Place, Bridgeport. Secretary, Dorothy C. Peckham, 370 Hamilton Avenue, Norwich.
- State Department of Health**—Hazel V. Dudley, Director, Bureau of Public Health Nursing, State Office Building, Hartford.
- State Tuberculosis Commission**—Helen M. Green, 155 Broad Street, Hartford.
- State Nurses' Association Paid Executive**—Margaret K. Stack, 252 Asylum Street, Hartford.

DELAWARE

- Section on Public Health Nursing of State Nurses' Association**—Chairman, Elizabeth Price Stone, Riverside Gardens, Wilmington. Vice-chairman, Rose Mazer Clark, Newark. Secretary, Anne Berger, Litwood, Wilmington.
- State Board of Health**—Alberta B. Wilson, Director, Division of Public Health Nursing, Dover.
- Delaware Anti-Tuberculosis Society**—Mrs. Ethelwyn Bacon, Superintendent, Preventorium, Sunnybrook Cottage, Marshallton.
- State Nurses' Association Paid Executive**—Mrs. Mildred A. Marshall, 914 Jefferson Street, Wilmington.

DISTRICT OF COLUMBIA

- Section on Public Health Nursing of Graduate Nurses' Association of District of Columbia**—Chairman, Regina Burns, 2205 K Street, Northwest. Vice-chairman, Irene M. Goolie, 1746 K Street, Northwest. Secretary, Helen O'Brian, 1261 New Hampshire Avenue, Northwest.
- District of Columbia Health Department**—Mrs. Josephine Pitman Prescott, Director, Bureau of Public Health Nursing.
- District Nurses' Association Paid Executive**—Edith M. Beattie, 1746 K Street, Northwest.

FLORIDA

- Section on Public Health Nursing of State Nurses' Association**—Chairman, Mrs. Audrey Gallion, 1215 Northeast 4 Street, Fort Lauderdale. Secretary, Marguerita Libby, Orlando.
- State Department of Health**—Ruth E. Mettinger, Director, Bureau of Public Health Nursing, Jacksonville.
- State Nurses' Association Paid Executive**—Mrs. Phyllis R. Leonard, P.O. Box 1007, St. Augustine.

GEORGIA

- State Organization for Public Health Nursing**—President, Vera Mingledorff, P.O. Box 335, Griffin. Secretary, Mrs. Palestine Coleman, Health Department, Thomasville. Treasurer, Mrs. Maud Fleming, Health Department, Gainesville. Chairman Membership Committee, Mrs. Eudelle Trawick, Sparta.
- State Department of Public Health**—Mrs. Abbie Roberts Weaver, Director, Division of Public Health Nursing, State Capitol, Atlanta.
- State Nurses' Association Paid Executive**—Durice Dickerson, 131 Forrest Avenue, Northeast, Apt. 11, Atlanta.

IDAHO

- State Department of Public Health**—Mrs. Edith Carr, Director, Division of Public Health Nursing, Boise.

ILLINOIS

- Section on Public Health Nursing of State Nurses' Association**—Chairman, Mrs. Hazel D. O'Neal, 307 South Wright Street, Champaign. Vice-chairman, Margirete Boom, 1004 Main Street, Evanston. Secretary, Mary Jane Fee, 1516 West Church Street, Champaign.
- State Department of Public Health**—Maude Carson, Chief, Division of Public Health Nursing, Springfield.
- State Nurses' Association Paid Executive**—June A. Ramsey, 1014 Willoughby Tower, 8 South Michigan Avenue, Chicago.

INDIANA

- Section on Public Health Nursing of State Nurses' Association**—Chairman, Leona Adam, 1098 West Michigan Street, Indianapolis. Vice-chairman, Dorothy V. Smith, 202 Franklin Street, Valparaiso. Secretary, Ethel McClung, District Health Department No. 3, 150 East Spring Street, New Albany.
- State Board of Health**—Ethel R. Jacobs, Consultant Nurse, Bureau of Public Health Nursing, Indianapolis.
- State Nurses' Association Paid Executive**—Helen Teal, 1125 Circle Tower Building, Indianapolis.

IOWA

- State Organization for Public Health Nursing**—President, Adah L. Hershey, Room 10, City Hall, Des Moines. Secretary, Norma A. Michaelson, District Health Office No. 10, Centerville. Treasurer, Mrs. Gladys Bradley, Sibley. Chairman Membership Committee, Leta Seaman, State Department of Health, Des Moines. Chairman Lay Members, Elizabeth Trei, Sibley.
- State Department of Health**—Marie Neuschaefer, Director, Division of Public Health Nursing, Des Moines.
- Iowa Tuberculosis Association**—Marguerite A. Pfeffer, Field Director, 301 Empire Building, Des Moines.

KANSAS

- Section on Public Health Nursing of State Nurses' Association**—Chairman, Elaine Thompson, 819 First National Bank Building, Wichita. Vice-chairman, Evelyn Hannon, State Department of Health, Topeka. Secretary, Ruth Cowles, 1426 Wood Row, Wichita.
- State Board of Health**—Beatrice Ditto, Director, Public Health Nursing, Capitol Building, Topeka.
- Kansas Tuberculosis and Health Association**—Velma G. Long, 824 Kansas Avenue, Topeka.

KENTUCKY

- State Organization for Public Health Nursing**—President, Lula B. McClain, 4445 South Sixth Street, Louisville. Secretary, Beatrice Daniel, Scott County Health Department, Georgetown.

Treasurer, Mrs. Lucille Couch Fentress, Muhlenberg, Greenville. Chairman Membership Committee, Mrs. Clara Tapp, Livingston County Health Department, Smithland.

State Department of Health—Margaret L. East, Director, Bureau of Public Health Nursing, Louisville.

State Nurses' Association Paid Executive—Mrs. Myrtle C. Applegate, 604 South Third Street, Louisville.

LOUISIANA

State Organization for Public Health Nursing—Acting President, Christine Causey, 3508 Chestnut, New Orleans. Secretary, Celine McGinn, 726 Avenue "G," Crowley. Treasurer, Grace Mizelle, Calcasieu Lake Charles Health Unit, Lake Charles. Chairman Membership Committee, Christine Wright, St. Mary Parish Health Unit, Franklin.

State Board of Health—Emma Maurin, Director, Division of Public Health Nursing, New Orleans.

MAINE

Section on Public Health Nursing of State Nurses' Association—Chairman, Helen Dunn, State House, Augusta. Vice-chairman, Velma Pettiner, 187 Middle Street, Portland. Secretary, Mrs. Delma Marshall, 187 Grove Street, Bangor.

State Department of Health and Welfare—Helen F. Dunn, Director, Division of Public Health Nursing, Augusta.

Maine Public Health Association—Theresa R. Anderson, 256 Water Street, Augusta.

State Nurses' Association Paid Executive—Mrs. Alice S. Hawes, 54 Saunders Street, Portland.

MARYLAND

State Organization for Public Health Nursing—President, Eleanor Immler, 31 South Calvert Street, Baltimore. Secretary, Charlotte von Briesen, 346 Rosebank Avenue, Baltimore. Treasurer, Mrs. Helen Cullins, 28 South Broadway, Baltimore. Chairman Membership Committee, Florence Haas, 31 South Calvert Street, Baltimore.

State Department of Health—Mariana H. Ward, Assistant Nurse Instructor, Division of Public Health Nursing, Baltimore.

State Nurses' Association Paid Executive—Mrs. Blanche G. Powell, 1217 Cathedral Street, Baltimore.

MASSACHUSETTS

State Organization for Public Health Nursing—President, Sophie C. Nelson, 197 Clarendon Street, Boston. Secretary, Mrs. Ben Ross Schneider, 21 Winthrop Street, Winchester. Treasurer, Mrs. Fritz H. Walking, 40 Clewley Road, West Medford. Chairman Membership Committee, Mrs. Thomas Worcester, 205 Putnam Street, Waltham.

State Department of Public Health—Ethel G. Brooks, Chief Supervisor, Public Health Nursing, State House, Boston.

State Nurses' Association Paid Executive—Helene G. Lee, 420 Boylston Street, Boston.

MICHIGAN

State Organization for Public Health Nursing—President, Anna Jenkins, Battle Creek. Secretary, Elizabeth Ober, 1688 Beach Street, Muskegon. Norma B. Eskil, Department of Public Health, Flint.

State Department of Health—Helene Buker, Director, Bureau of Public Health Nursing, Lansing.

State Nurses' Association Paid Executive—Olive Sewell, 750 East Main Street, Lansing.

MINNESOTA

State Organization for Public Health Nursing—President, Anna S. Nyquist, 815 Essex Street, Southeast, Minneapolis. Secretary, Mrs. Frances E. Shelley, 1520 East Minnehaha Parkway, Minneapolis. Treasurer, Sanford Gustaf-

son, Hopkins. Chairman Membership Committee, Emily Mosford, 2642 University Avenue, Southeast, Minneapolis.

State Department of Health—Ann S. Nyquist, Acting Director, Division of Public Health Nursing, St. Paul.

Minnesota Public Health Association—Mabel Johnson, 11 West Summit Avenue, St. Paul.

State Nurses' Association Paid Executive—Caroline Rankiellour, 2642 University Avenue, St. Paul.

MISSISSIPPI

Section on Public Health Nursing of State Nurses' Association—Chairman, Nettie V. Turner, Itta Bena.

State Board of Health—Mary D. Osborne, Director, Public Health Nursing, Division of County Health Work, Jackson.

MISSOURI

Section on Public Health Nursing of State Nurses' Association—Chairman, A. Mary Ross, 3408 Kenwood, Kansas City. Vice-chairman, Gertrude Kuntz, 4116 Shenandoah, St. Louis.

State Board of Health—Ella Mae Hott, Director, Division of Public Health Nursing, Jefferson City.

State Nurses' Association Paid Executive—Mary E. Stebbins, 1512 Waldheim Building, 6 East 11th Street, Kansas City.

MONTANA

State Organization for Public Health Nursing—President, Freda Miller, Department of Public Welfare, Billings. Secretary, Mrs. Virginia Geiger Hanks, Lewiston. Treasurer, D. Camilla Lunde, 1414 Second Avenue North, Great Falls. Chairman Membership Committee, Helen Murphy, State Board of Health, Helena.

State Board of Health—Florence V. Whipple, Supervisor of Public Health Nursing, Division of Maternal and Child Health, Helena.

Montana Tuberculosis Association—Henrietta Crockett, Executive Secretary, Helena.

State Nurses' Association Paid Executive—Mrs. Margaret Carolus Alsop, Room No. 1, Lalonde Block, Helena.

NEBRASKA

State Organization for Public Health Nursing—President, Mrs. Elsie Webster, 140 North 43 Street, Omaha. Secretary, Edna Brown, University Hospital, 42nd and Dewey, Omaha. Treasurer, Mrs. Murrell Johnson, 2590 Woodside, Lincoln.

State Department of Health—Eleanor Palmquist, Director, Division of Public Health Nursing, Lincoln.

State Nurses' Association Paid Executive—Halcie M. Boyer, 626 Electric Building, Omaha.

NEVADA

State Department of Health—Mrs. Christie A. Thompson, State Supervisory Nurse, Division of Maternal and Child Health, and Crippled Children's Services, 12 Fordonia Building, Reno.

NEW HAMPSHIRE

Section on Public Health Nursing of State Nurses' Association—Chairman, Florence M. Clark, 32 Church Street, Concord. Vice-chairman, Mrs. Helena C. St. Hilaire, 195 Sagamore Street, Manchester. Secretary, Mrs. Lurline H. McCook, 360 Main Street, Tilton.

State Board of Health—Mrs. Mary D. Davis, Director, Division of Public Health Nursing, Concord.

State Board of Education—Elizabeth M. Murphy, Supervisor of Health, Concord.

NEW JERSEY

State Organization for Public Health Nursing—President, Evelyn T. Walker, 131 Pearl Street, Red Bank. Secretary, Mrs. Mildred Matthews,

348 Beaufort Avenue, Livingston. Treasurer, Dr. Emil Frankel, State Department of Institutions and Agencies, Trenton. Chairman Membership Committee, Emily K. Lydon, 42 Park Place, Newark.

State Department of Health—Elizabeth Curtis, State Advisory Public Health Nurse, Bureau of Local Health Administration, Trenton.

State Department of Public Instruction—Lula P. Dilworth, Associate in Health and Safety Education, Trenton Trust Building, Trenton.

State Nurses' Association Paid Executive—Wilkie Hughes, 17 Academy Street, Newark.

NEW MEXICO

Section on Public Health Nursing of State Nurses' Association—Chairman, Victoria Mayer, State Department of Health, Santa Fe. Secretary, Mildred Keith, Mosquero.

State Department of Public Health—Mrs. Fannie T. Warncke, Director, Division of Public Health Nursing, Santa Fe.

NEW YORK

Section on Public Health Nursing of State Nurses' Association—Chairman, Clara M. Chitwood, 675 Delaware Avenue, Buffalo. Vice-chairman, Ethel Phillips, Director, Visiting Nurse Association, Federal Building, Elmira. Secretary, Veronica Donnelly, Director, Public Health Nursing Health Center, Yonkers.

State Department of Health—Marion W. Sheahan, Director, Division of Public Health Nursing, Albany.

State Education Department—Anna M. Neukom, Supervisor of School Nursing, State Education Building, Albany. Marie Swanson, Senior Supervisor of School Nursing, State Education Building, Albany.

State Nurses' Association Paid Executive—Emily J. Hicks, 152 Washington Avenue, Albany.

NORTH CAROLINA

Section on Public Health Nursing of State Nurses' Association—Chairman, Louise Croom, Roxboro. Vice-chairman, McVeigh Hutchison, Lexington. Secretary, Mrs. Louise P. East, State Board of Health, Raleigh.

State Board of Health—Amy L. Fisher, Public Health Nursing Consultant, Division of County Health Work, Raleigh.

State Nurses' Association Paid Executive—Mrs. Marie Brock Noell, 415 Commercial Building, Raleigh.

NORTH DAKOTA

Section on Public Health Nursing of State Nurses' Association—Chairman, Gladys Wentland, Lisbon. Vice-chairman, Mrs. Mildred McDonald, Dickinson. Secretary, Mrs. Mona E. Anderson, Rugby.

State Department of Health—Irene Donovan, State Supervisor of Public Health Nursing, State Capitol, Bismarck.

OHIO

Section on Public Health Nursing of State Nurses' Association—Chairman, Mary I. Brenehan, 12512 Shaw Avenue, Cleveland. Vice-chairman, Bertha Henderson, 2924 Collingwood Avenue, Toledo. Secretary, Mrs. Evelyn J. Thorne, 3547 Dover Road, Youngstown.

State Department of Health—S. Gertrude Bush, Chief, Nursing Division, Columbus.

State Nurses' Association Paid Executive—Mrs. Elizabeth P. August, 50 East Broad Street, Columbus.

OKLAHOMA

State Organization for Public Health Nursing—President, Jessie Younger, 816 East 18 Street, Ada. Secretary, Louise Shedd, State Health Department, Oklahoma City. Treasurer, Helen Bonneau, Kay County Health Department, Ponca City. Chairman Membership Committee, Mrs. Harry O. Hamm, 1730 East Delaware, Tulsa.

State Department of Public Health—Josephine L. Daniel, Director, Division of Public Health Nursing, Oklahoma City.

Oklahoma Tuberculosis Association—Mrs. Thelma Goodrich, 22 Northwest Sixth Street, Oklahoma City.

OREGON

State Organization for Public Health Nursing—President, Aileen Dyer, 1206 Southwest Gibbs Street, Portland. Secretary, Mrs. Margaret Payton, 3914 Southeast 64 Avenue, Portland. Treasurer, Johanna Eggers, 3417 Southwest Twelfth Street, Portland. Chairman Membership Committee, Helen Fisher, 2014 Northwest Glisan, Portland.

State Board of Health—Lucile Perozzi, Director, Division of Public Health Nursing, 816 Oregon Building, Portland.

State Nurses' Association Paid Executive—Mrs. Linnie Laird, 205 Stevens Building, Portland.

PENNSYLVANIA

State Organization for Public Health Nursing—President, Mathilda Scheuer, 1340 Lombard Street, Philadelphia. Secretary, S. Margaret Smith, Phipps Institute, Seventh and Lombard Streets, Philadelphia. Treasurer, Mrs. Anna R. Barlow, Visiting Nurse Association, Reading. Chairman Membership Committee, Clarissa Gibson, Visiting Nurse Association, Scranton.

State Department of Health—Alice M. O'Halloran, Director, Bureau of Public Health Nursing, Harrisburg.

State Department of Public Instruction—Position of School Nursing Adviser, vacant.

State Nurses' Association Paid Executive—Mrs. Katharine Miller, 400 North Third Street, Harrisburg.

RHODE ISLAND

State Organization for Public Health Nursing—President, Mary G. Walsh, 136 Whitford Street, Providence. Secretary, Helen E. Sammis, 201 Brookdale Boulevard, Pawtucket. Treasurer, Mrs. Agnes B. Cameron, Belvedere Boulevard, North Providence. Chairman Membership Committee, Rita Murphy, 25 Adelaide Avenue, Providence.

State Department of Health—Edith Budlong, Acting Public Health Nursing Consultant, Division of Administration, Providence.

State Nurses' Association Paid Executive—Anna J. Delmore, 42 Weybosset Street, Providence.

SOUTH CAROLINA

Section on Public Health Nursing of State Nurses' Association—Chairman, Hettie Hough, State Board of Health, Columbia. Vice-chairman, Mrs. Mary B. Bonner, Abbeville County Health Department, Abbeville. Secretary, Mattie Ingram, Beaufort County Health Department, Beaufort. Publicity Chairman, Mrs. Ruth George, State Board of Health, Columbia.

State Board of Health—Mrs. Ruth George, State Supervising Nurse, Division of County Health Work, Columbia.

State Nurses' Association Paid Executive—Nellie Cunningham, 306 Carolina Life Building, Columbia.

SOUTH DAKOTA

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PUBLIC HEALTH NURSING

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When Does the Home Front Have Priority?

THE RECENT announcement that the Army is 5,000 short of the number of nurses needed to meet its present needs renews a struggle in the minds of young public health nurses. Their own personal desire to serve their country by entering military service plus the considerable pressure of public opinion that they do this is hard to resist. Yet they have also been told authoritatively that most of them are needed for essential public health service in their own or some other community. The annual report of the American Red Cross for the year ending June 30, 1942 which has just appeared makes this statement about the public health nurse:

The public health nurse, whether employed by an official or nonofficial agency, is destined to play an important role in national defense. The need for the services of these nurses in every community is apparent. For this reason health officials and directors of nursing services are asking that these nurses be permitted to contribute to the national war effort by continuing to serve the people in their own communities.

Until or unless nurses are drafted, each one in the last analysis must decide for herself where her best service in the war effort can be rendered. It is important in making her decision that she consider all sides of the question. Popular demand and emotional appeal are on the side of military service. The needs of the Home Front, though less dramatic, are very real. They are vividly presented in a letter written recently by Dr. William P. Shepard, well-known public health physician of the West Coast. Health officers in many other parts of the country tell a similar story. Dr. Shepard's letter is pre-

sented here to show the public health side of the problem.

Increasing pressure for public health nurses to enlist is becoming apparent in the West Coast. It is the public health nurses who are more conscious of community needs and, therefore, more prompt in responding to a national appeal.

Knowing what I do of nurses' duties in the Army and Navy, I cannot but feel that this an unwarranted waste of woman power when public health needs of the civilian population are becoming so urgent and complex. These needs are particularly acute in the many war production areas on this Coast. Out here, industry was less important than mining and agriculture until now.

Almost overnight great cities of industrial workers have suddenly sprung up where there was little population before. Many small towns have doubled their population and I can name ten or fifteen in which the population has been tripled or quadrupled.

Until you see it, you cannot conceive of the serious public health problems this entails. In some of these areas, sewer manholes are overflowing into the streets; rat population, always a serious plague menace on this Coast, has even outstripped human population increases; sanitation of public eating places has broken down; immunization is being neglected. Hospitalization is at a premium in all places and actually unobtainable in many. Remaining physicians are so overworked they must refuse all house calls. One doctor told me the other day a frantic mother phoned that her child had been lying on his head and heels, unconscious, with a high fever, since four that afternoon. He was the fifth doctor she had called and all had been unable to come. He, too, was obliged to decline the call. Deliveries are taking place in homes without even a midwife, let alone a physician, and mothers are being discharged from the hospitals three days postpartum.

Government housing projects are excellent where they exist, but are still woefully behind. Many thousands are living in trailers, some trailers accommodating as many as eight people, without adequate water and sewage facilities.

PUBLIC HEALTH NURSING

For the first time in my memory, organized medical groups, such as county societies and the California Physician's Service, Inc., are appealing for bedside nursing programs. Despite all this, somewhere in the nursing profession there is coercion of public health nurses to join the armed forces.

The purpose of this letter is to ask your opinion as to whether voluntary enlistment of nurses is likely to be stopped as have voluntary enlistments elsewhere. Do you see any imme-

diately hope of nurses coming under the War Manpower Commission and in that way being handled in a logical manner?

With the winter upon us, which on this Coast means wet clothes and wet feet, and with the overcrowding and migratory problems described above, I am deeply concerned lest this war might be lost on the home front because of lack of wisdom in using trained people where they can do the most good.

R. H.

Will Food Win the War----and Peace?

IT CAN—but only with wholehearted and rapid cooperation of millions of people in major production and redistribution plans. And public health workers can be key persons in enlisting this help.

Public health workers know intimately both the basic importance of adequate diets and the primary reactions of people to manipulations of the national larder. Enough experience with rationing has already been observed to realize the need for many explainers and interpreters who know food facts, and are sufficiently convinced of the potentialities of redistribution to help others understand it. In relation to the new point rationing system which is about to go into effect, they can turn the tide of public opinion and comment from pessimism to optimism, from complaint to cooperation.

The medical professions are used to acknowledging that wars have brought great advances in therapeutic measures. It should not be hard, therefore, for them to recognize that this war period may be a nutritional boon.

With almost limitless capacity for food production in this country, fully one third of Americans are poorly fed. The low-income groups do not have enough money. Many families are without the facilities or skill to raise food at home. Others lack the knowledge necessary to wise food

choices. Still others simply have bad food habits. Even among farm families at least a quarter have inadequate diets. Nutritional deficiencies, directly or indirectly, have disqualified about one man in seven for military service. Couple these facts with studies showing large wastage of food all along the line from producer to the man at the dinner table, variations in weekly meat consumption averaging 1½ pounds for low-income to 5 pounds for high-income families, and the need for planned distribution begins to stand out in bold relief. Reflect this against a hungry world outside our borders and food distribution appears even more urgent.

The possibilities of planned distribution are evident to public health workers who have watched at close range the handling of surplus foods change from planned destruction and wastage to the school lunch and milk programs, the food stamp program which enabled millions of needy Americans to increase their food allotment by 50 percent! Mistakes will occur in rationing, but if everyone tries to make it go, great strides may be made in 1943.

What does this mean to public health nurses? It means taking an informed, cooperative attitude into every home visited and into every group meeting led. It means practicing economy and resource-

(Continued on page 86)

Wartime Modifications in Public Health Nursing Services for the Sick

PREPARED BY THE
NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING*

REDUCTIONS in professional nursing personnel in many communities are accompanied by expanded requirements for nursing services to the sick. This is particularly true where the population has grown far above normal size due to industrial and military activity. Public health nursing agencies responsible for nursing the sick in their homes must modify their procedures to enable them to maintain essential and often additional services with the utmost economy of nursing personnel.

To keep public health nurses and agencies informed about modifications under consideration or already put into practice, the N.O.P.H.N. has assembled such information and opinion as is available at the present time. This is not by any means a comprehensive picture of all that can be done in the way of streamlining, but it is hoped that the procedures described will suggest ways by which present emergency needs can be met. This statement is the third in a series on wartime modifications in public health nursing. The first, on administrative adjustments, and second, on industrial nursing, appeared in the December 1942 and January 1943 issues respectively of PUBLIC HEALTH NURSING.

I. Review of Intake Policies

Most visiting nurse associations accept all new calls for at least one visit. This first visit can be more wisely planned if as much pertinent information is secured as possible at the time the call is taken. Answers to the following questions will help the supervisor in planning the day's work:

How long has the patient been sick? Is he in bed? Has he an elevation of temperature? How much? Is he vomiting? Has he pain? If so, where and how severe? What other symptoms has he? Is he alone or who is staying with him? A neighbor? Someone in the family? An adult or a child?

Selection of cases may be further influenced by a consideration of known family circumstances, such as:

The intelligence and competency of family members; cooperativeness; the general health situation; the social situation; the amount and success of past health teaching; the social services now being given to the family and their relation to the health services.

*Through a Special Committee to Consider Wartime Adjustments.

PUBLIC HEALTH NURSING

A review of cooperative agreements with other agencies, especially with social service departments of hospitals, should be held regularly to insure a clear understanding of the types of patients for whom public health nursing is definitely needed and who should be referred for this service.

II. Adjustments in Types and Spacing of Visits

1. *First visits.* Every public health nurse should on her first visit explain carefully and sympathetically to all families the need for utilizing her time wisely by helping her all they can and assuming as much subsequent care as possible. This will allow for wider spacing of some visits. The assistance of relatives, neighbors, or auxiliary workers can be urged. In a large agency staff nurses will find it very helpful to have a simply-worded, printed bulletin to leave which explains in detail the reasons for the present need to "ration" nursing, and the conditions under which the agency can furnish nursing care, together with the charges made to those who can pay.

2. *Appointment visits.* Both pay and nonpay services will have to be carefully budgeted to save the public health nurse's time. Under an appointment plan services are less flexible and hence more time-consuming, and should therefore be reduced to the minimum. Patients should be seen in order of their sickness needs.

3. *Luxury service.* To families accustomed to employment of private duty nurses, the use of public health nurses on a pay basis represents to them the elimination of "luxury" service and the reduction to basic needs. A careful explanation is due all families about the need for limiting the use of nurses' time to only those services for which a professional is necessary. Such co-operation is necessary to assure good care to them and the community. Certain types of non-nurse services and kinds of treatments formerly given to some patients will need to be eliminated. Among these are colonic irrigations which are frequently not necessary therapeutically. In each instance adjustment will be made according to the situation found in the individual home and with each patient and his physician.

4. *Nonproductive visits.* Every conceivable means of cutting down non-productive activities, such as "not home" visits should be employed. This entails the fullest possible use of correspondence and telephone. It may necessitate a change of nursing hours where industrial workers are concerned. Initiative in reporting to the nurse should be encouraged in families needing or receiving public health nursing service.

III. Substitutes for Some Home Visits

1. *Use of nursing center for treatments.* Certain kinds of care or treatment usually given in the patient's home can well be given in a nursing center if the patient is able to leave his home. If these are planned for definite days and specific hours, much time of the public health nursing personnel can be saved for service instead of travel. Examples of care that can be given at the

BEDSIDE CARE OF SICK IN WARTIME

center are hypodermics, certain orthopedic treatments, dietary instructions, and some dressings.

2. *Group instruction and service.* Group methods should be utilized wherever possible in such services as tuberculosis, maternity, diabetes, rheumatic fever, and others to reduce travel time spent by public health nurses and to allow more widely-spaced home visits. Families accustomed to call the nurse for many minor illnesses should be urged to have a member attend a home nursing class.

3. *Utilization of service of auxiliary workers.* The criteria for assignment of auxiliary workers for services in the home should be the condition of the individual patient at a given time and the particular situation in his home, rather than general categories of diagnosis or economic status. No patient will therefore be permanently assigned to one auxiliary worker but will have visits from the public health nurse interspersed with carefully-supervised visits from another such worker. At the time when the use of auxiliary workers for the care of the sick is being considered, a complete review of all cases under care of the agency will be necessary in order to determine how this type of worker can best serve.

IV. Conservation of Time for Public Health Nurses by Use of Non-nurse Helpers

It has been found that a non-nurse helper carefully trained for the job can clean and pack nurses' bags, care for supplies, keep cupboards clean, and carry on other similar necessary tasks. Such help can be secured from volunteer or paid workers on a six-day-week basis.

A careful scrutiny of the physical setup of the office may show ways by which a rearrangement of equipment will eliminate waste motion. Efficient planning is especially necessary in small storage spaces or utility rooms so that the flow of work is smooth.

Telephone service should be studied to learn whether nurses are delayed in making their calls during the short time they are in the office. Extra telephone equipment should be provided, if necessary, so as to make best use of nurses' time, or hours for telephoning staggered for the separate nurses.

THE AMERICAN JOURNAL OF NURSING FOR FEBRUARY

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Nutrition in Public Health Nursing

By MARY J. DUNN, R.N.

"Where are we going?" applies to nutrition as well as to other public health nursing aims. The Public Health Nursing Curriculum Guide has helped to chart our course

THAT NUTRITION continues to present a serious and widespread public health problem is a truism of great concern to all of us. To quote Dr. Russell M. Wilder of the Mayo Foundation, "The campaign for better nutrition is complicated by cultural, social, and economic problems. The principal battles of the army of nutrition will be fought in fields of education, economics, and industry. Guidance can be provided by research, but the success of the campaign will depend on the effort of each of the several groups with special trainings that now are gathering for action. We must come to recognize as a nation that every one of us individually carries a responsibility for the welfare of our fellow citizens. May we always hold as an ideal that this nation will some day be a nation of buoyantly healthy people."*

This goal can be attained when we as health workers translate our knowledge of nutrition into everyday reality for all the people. *To those who are responsible for the preparation of public health nurses,* What are you doing to make the teaching of nutrition more effective? *To those who are serving in health agencies,* Are you recognizing and making the most of every opportunity in your everyday prac-

tice to stimulate individual and group learning in nutrition? To aid in the attainment of such goals was the spirit behind the preparation of The Public Health Nursing Curriculum Guide.

Almost a year has elapsed since the Guide went to the publishers. However, a brief review of the inception, purpose, and procedure which finally resulted in the printed Guide seems indicated as a background for the discussion of that portion of it which deals with nutrition.

The need for such a Guide had long been expressed, particularly by those primarily responsible for the guidance, direction, and teaching of public health nursing programs of study. Consequently, the National Organization for Public Health Nursing requested the U. S. Public Health Service to participate in a joint project to study public health nursing curricula. In response to this request, the writer was assigned to this task in February 1940.

A Central Advisory Committee** was appointed. One of the earliest tasks of this committee was to set forth the following objectives and scope of the study: to determine the knowledge, attitudes, interests, abilities, and professional skills which the public health nurse practitioner

*The National Nutrition Conference. *Public Health Reports*, June 13, 1941, p. 1240.

**See PUBLIC HEALTH NURSING, March 1940, p. 208.

See The Public Health Nursing Curriculum Guide, p. 195.

NUTRITION IN PUBLIC HEALTH NURSING

should have in order to function with professional competence in relation to the health needs of individuals, families, and the community, as well as in relation to the various phases of the public health program.

It was further proposed that emphasis be placed on the preparation of the public health nurse *practitioner*, as distinguished from the advanced preparation of the public health nursing supervisor, administrator, or instructor, and that the study be concerned only with the professional content based on the assumption of satisfactory basic nursing education.

Thus, the Central Committee outlined *what* was to be accomplished. The somewhat more difficult task of *how* it was to be accomplished was next given consideration. As a first step, it was deemed necessary to arrive at some agreement as to the major health areas in which the public health nurse functions. After a great amount of deliberation, the following sixteen functional areas were agreed upon:

- Maternal Health
- Infant Health
- Health of the Preschool Child
- Health of the School Child
- Industrial Hygiene
- Mental Health, Mental Disease, and Mental Defect
- Nutrition*
- Oral Health
- Acute Communicable Diseases
- Tuberculosis
- Venereal Diseases
- Pneumonia, Influenza, and the Common Cold
- Cancer
- Diabetes
- Heart Diseases
- Orthopedic and Plastic Conditions

The second step was the formulation of the general public health objectives pertaining to these various functional areas, with sufficient breadth to include the

entire public health program, realizing that public health nursing does not operate in isolation but as an integral part of the whole field of public health. Logically this led to a third step—the redefining of public health nursing functions based on these previously formulated public health objectives. In the formulation and revision of the objectives and functions, invaluable assistance was given by many persons well versed in the various branches of public health and public health nursing. These objectives and functions, in turn, served as the bases in determining what the public health nurse needs to know, and the skills she should possess in order to function with professional competence in the public health program.

The fourth step was the appointment of sixteen production committees* whose responsibility was the preparation of the material for a designated health area—this to include the knowledge and skills needed by the public health nurse, and suggestions leading to their attainment. These committees centered about the universities offering approved public health nursing programs of study, and membership consisted of two groups of public health nurses: (1) those in universities engaged in the preparation of public health nurses and (2) those in service agencies utilizing the products of the various public health nursing programs of study. In addition, many persons in allied or special fields served as consultants to the production committees.

Topics to be developed were assigned to the various production committees after careful consideration and in relation to the peculiar problems and research on a given subject in a given geographical area, as well as the particular interest and ability of committee members and available consultants within such an area. Advice and consultation also were sought from those

*Memberships of Production Committees are to be found in the Guide, Appendix, p. 197.

well versed in general education and curriculum construction.* They gave invaluable assistance in evolving a curriculum pattern which seemed to lend itself best to the presentation of this particular material.

After the production committees had completed their respective reports, the fifth step was to distribute these reports to reviewers throughout the country for further suggestions as to enrichment, correction or deletion of content. The interest manifested and the generous assistance given by these reviewers are worthy of special mention. Their suggestions proved of inestimable help in the final editing of the manuscript. It should be noted that over 200 persons participated in this project which has been truly national in scope.

So much for the origin and evolution of The Public Health Nursing Curriculum Guide. The remainder of this discussion will center about the place and content of nutrition in the Guide, and those responsible for the preparation of the chapter on nutrition. It may be of interest to mention that in some of the earlier discussions the question arose as to whether nutrition should be considered separately as one of the sixteen functional areas, or whether it should not be dealt with as an integral part of the other fifteen areas. The final decision was to do both: that is, to crystalize the nutrition content of the Guide as a separate and distinct chapter, and also to incorporate it as a vital element of the other fifteen functional areas covered in the Guide. As another point of interest, of the some 30 universities or colleges now offering approved public health nursing programs of study, 26 provide courses in nutrition, varying from one to four point courses, while the remaining four do not provide separate courses in nutrition.

*The names of these consultants are to be found in the Guide, Appendix, p. 195.

The chapter on nutrition can be found in its entirety in The Public Health Nursing Curriculum Guide, but there is reviewed here the divisions titled Public Health Objectives and Public Health Nursing Functions which guided the Nutrition Production Committee in outlining the units on this subject:

I. Public Health Objectives

A. The promotion of optimum efficiency and the prolongation of a healthful life for every individual by providing the essentials of good nutrition throughout the life cycle. This may be accomplished through:

1. Appreciation of the nutritional aspects in every phase of health service.
2. Understanding and practice by every individual of a health regimen, including good dietary practice, that will tend to promote health and efficiency.
3. Emphasis on the importance of proper nutrition for every pregnant and lactating woman as a means of protecting her own health, of supplying materials needed for the baby's development, and of establishing and maintaining lactation.
4. Development, particularly in children, of attitudes toward food and habits of eating that will make for good nutrition.
5. Constructive adjustments in diet by making greater use of the natural foods in preference to overrefined foods and vitamin concentrates.
6. Support of measures for the necessary economic and social adjustments to make an adequate diet available to everyone.
7. Development of community understanding, interest, and action in providing such educational facilities and services as will promote the general health and nutritional status of every individual.

B. The restoration to health of every malnourished individual, and the reduction of death, illness, and disability caused or aggravated by nutritional deficiencies. This may be accomplished through:

1. Appreciation of the importance of diet in the treatment of disease.
2. Provision for adequate medical, dental, and nursing supervision, particularly for young children, to insure early detection and correction of malnutrition.
3. Recognition and prompt treatment of early symptoms of nutritional deficiencies, including manifest disease caused by marked deficiency of dietary essentials,

and also the more common latent deficiency conditions due to less extreme deficiency of dietary essentials.

4. Correction of those physical defects which may interfere with normal nutrition, such as decayed or maloccluded teeth, enlarged or diseased tonsils, and faulty posture.
5. Correction of conditions that may be due to faulty habits of hygiene, and that interfere with normal nutrition, such as lack of appetite, constipation, overfatigue, and mental anxiety.
6. Support of measures for such social and economic adjustments as may be needed for the correction of malnutrition.
7. Utilization of all community resources in meeting satisfactorily the existing problems in the field of nutrition.

II. Public Health Nursing Functions

A. The public health nurse:

1. Instructs individuals and groups in the basic principles of nutrition, the food requirements of healthy individuals, the influence of proper nutrition upon normal growth and development, and the maintenance of good health.
2. Teaches the nutritive value of everyday foods, encouraging the greater use of natural foods as contrasted with overrefined foods and vitamin concentrates.
3. Assists the individual and the family with the proper selection of foods for an adequate diet, taking into consideration the family's dietary habits, social customs, and economic status, as well as the kinds and amounts of food available.
4. Instructs pregnant and lactating mothers in the need for an adequate diet to protect their health, to furnish the materials needed for the baby's growth and development, and to maintain lactation.
5. Assists parents in establishing good feeding habits in infants, and in developing in children proper attitudes toward food and habits of eating which should contribute to normal growth and development.
6. Assists in the correction of faulty attitudes and habits of eating which tend to result in malnutrition and impaired health.
7. Emphasizes the importance of good hygienic measures, and of avoidance of those conditions, such as lack of appetite, constipation, overfatigue, and mental anxiety, which predispose toward malnutrition.
8. Instructs parents, teachers, and others concerned, in the early recognition of conditions that are related to poor nutri-

tion, and the necessity for prompt medical and dental care.

9. Instructs in the cause, early symptoms, and importance of adequate care and treatment of conditions and diseases caused or aggravated by nutritional deficiency.
10. Assists in securing adequate care for all individuals who may have developed a disease caused or aggravated by nutritional deficiency.
11. Gives, demonstrates, and supervises nursing and dietary care of all individuals to whose care diet makes a contribution, including those with a nutritional deficiency condition or disease.
12. Promotes community understanding of and interest in the importance of good nutrition for everyone, and stimulates the development of community facilities and services for the promotion of normal nutrition, and for the early recognition and correction of nutritional defects.
13. Works jointly with all community agencies toward making such social and economic adjustments as may be necessary in securing for every individual a diet that is essential for normal growth and development and for the maintenance of good health.
14. Evaluates the effectiveness of public health nursing performance in promoting good nutrition.

In developing the chapter on nutrition, effort was directed toward the inclusion of content that would lead to:

1. . . . Better understanding of existing knowledge and trends in the field of nutrition, essential to effective public health nursing performance.
2. . . . Understanding of the public health aspects of nutrition, and ability to apply this knowledge in carrying out public health nursing functions in the nutrition program.

The Nutrition Production Committee* was centered in Tennessee, with representation from the two approved public health nursing programs of study—George Peabody College for Teachers and Vanderbilt University—as well as from the Tennessee State Department of Public Health, and municipal, county, and private health

*Membership of Committee is to be found in the Guide, Appendix, p. 198.

PUBLIC HEALTH NURSING

agencies. The writer had the privilege of working with this particular committee; the fine spirit and productive effort manifested by this group merit special comment.

Likewise, the reviewers of the Nutrition chapter, representing nationally-known specialists, have contributed greatly to enriching and improving this particular chapter of the Guide. Many of the reviewers stressed the point that, no matter how good the content might be, in the last analysis, the worthwhileness of this material will be in relation to the teaching ability of the instructor and the learning situation of the student, and further, as said before, to the power of public health nurses as teachers to translate our knowledge of nutrition into everyday reality for our people.

A functioning curriculum in wartime especially demands that we:

1. Explore effective ways of working with individuals, families and groups

2. Provide an environment which offers experience in problem solving

3. Discover and use effective means of evaluating work

Therefore, to the extent that The Public Health Nursing Curriculum Guide is accepted as a "trial balloon" to be experimented with, its adequacies and inadequacies pointed out, and revisions made, can it serve as a dynamic influence in the more effective preparation of that ever-increasing corps of health workers—namely, the public health nurses of the country.

Presented before the Joint Session of the Public Health Nursing and Food and Nutrition Sections, Annual Meeting, American Public Health Association, St. Louis, Missouri, October 29, 1942.

Will Food Win the War?

(Continued from page 78)

fulness in buying, cooking, and eating until such a storehouse of suggestions is acquired that sharing these facts will be second nature. The public health nurse who knows and likes many ways of preparing the cereal foods, who is very familiar with the abundant carrot, onion, cabbage, and turnip, who knows ways to make meat "go a long way" for seasoning, and how to substitute proteins through dairy products and legumes—the nurse who is going to try a victory garden of her own, no matter how small—can make special contributions in health, even by her own example.

This will be a real test also of her ability to learn from as well as to teach families. The mother who works from 8 to 5 rounded out one nurse's information and won her admiration when asked, "Are you having difficulty getting butter within store hours?" She replied, "Oh, no. I don't need it often; we drink more milk

and I season vegetables like my mother used to, with bacon drippings. For baking fat, I cook a nice fat chicken on Sundays. Poultry is cheaper than most meats now, you know, and can be stretched out to last several days." Can we match our resourceful mothers?

Because this great effort to redistribute foods in fairness to all is about to involve the families we serve through the point rationing system, this issue of PUBLIC HEALTH NURSING gives special emphasis to nutrition. Mary Dunn takes us back to fundamentals in her thoughtful article. Dr. Gebhard demonstrates the truth of the old adage, "a picture is worth ten thousand words." How one lay volunteer helped a nursing agency to teach nutrition is told by Gladys Cook, while Julia Dwight describes how a group of nurses became interested in their own nutritional state. Let us learn and share. Let's turn this war period to positive account for the better nutrition of our country.

L. B.

The Newer Knowledge of Malnutrition

By JULIA C. DWIGHT*

Public Health Nurse, know thyself! is the lesson in this study which sought evidences of nutritional deficiencies among a group of public health workers

NEW INSIGHT into an individual's past and present health status has recently been gained by the use of new methods for detecting and reading the stories written clearly in the body's tissues. These microscopic but truthful records of the ravages of disease, poor diet, and other factors have been discovered with the aid of the biomicroscope. Such information is of great value, not only because it shows how the individual's health may be improved at present, but also how it may be safeguarded in the future.

Since the first faint glimmerings of the idea that food and health might bear a vital relationship to each other, those interested in this field of nutrition have realized that the diet of the average man in the street has not been the best possible one to protect his health. All dietary surveys, conducted to find out just what this so-called average man was eating, have shown this very clearly. The Department of Agriculture's national survey in 1935,¹ reported the amazing fact that over 34 percent of our American population had diets that were below the safety line as far as health was concerned. On the other hand, there were relatively

few cases of actual deficiency diseases in the population, and for want of anything better, deficiency disease had been considered the real proof of a dietary deficiency. Because of this, many people—even well-trained, professional people—reached the conclusion in their own minds that these dietary surveys were more or less meaningless, that probably people did not need as much of the protective proteins, minerals, and vitamins as nutrition specialists said they did. And certainly they, and everyone else they knew, were well-nourished because they showed no signs of the well-known, advanced, deficiency diseases. This point of view is still held by many intelligent people.

In the past few years, nutrition research has focused more and more attention on the so-called "sub-clinical" or "latent" deficiency states. These terms refer to the early period in the development of a deficiency disease, before the serious, well-recognized signs are present. It has been widely acknowledged by physicians working in this field that these states are far more prevalent among the population than is usually recognized,² but the difficulty has always been to diagnose these early symptoms of the deficiency diseases. These symptoms are usually generalized and in many cases are not so startling that the patient takes his complaints to a physician. If he did, the

*This article was prepared with the assistance of Dr. H. D. Kruse whose work with the Henry Street group has been carefully observed by the author.

PUBLIC HEALTH NURSING

physician had no clear-cut diagnostic methods at his disposal to determine the cause of the trouble, and as a result, in many cases it was blamed on causes other than nutritional.

Methods of diagnosis that have been used to measure nutritional status have been the height-weight-age relationship, body measurements, blood studies, and urine studies. Weaknesses have been discovered in each of these methods, however, and there is today much confusion as to their validity and usefulness.^{3, 4}

FOR the past few years, Dr. H. D. Kruse of the Milbank Memorial Fund has been working with new diagnostic methods for showing not only the presence but also the degree of the development of a deficiency disease. These methods have been, for the most part, microscopic examinations of the living tissues of the individual, to determine the degenerative changes taking place in specific tissues during the development of a deficiency disease. He has shown that during the early stages of vitamin A deficiency, definite microscopic changes are taking place in the conjunctiva of the eye,⁵ in ascorbic acid deficiency, changes in the gums,⁶ in riboflavin deficiency, changes in the cornea of the eye,⁷ and in niacin deficiency, changes in the tongue.⁸

The results of his studies on hundreds of persons, taken from different income levels, has shed new light on our whole understanding of deficiency diseases.⁹ Evidence is clearly present in the tissues of these people that points to two distinct types of the same deficiency disease: (1) the acute type of disease caused by a sudden, marked deficiency of a specific nutritive essential and (2) the chronic type of the same disease, which develops slowly due to the accumulative effect of a slight deficiency over a long period of time. For the purpose of classifying the degree of deficiency present, these two types of deficiency disease are subdivided further

into mild and advanced, making four classifications in all: mild or subacute, and advanced acute; mild chronic and advanced chronic. Besides the difference in time that it takes these two types of the same disease to develop, there are other clearly distinguishable characteristics of each. In the first place, they each produce distinct types of changes in the body tissues. Also, the period of time necessary for cure with therapy differs, being comparatively short for the acute type of disease which develops quickly, and much longer, extending into months and even years, for the chronic type which takes much longer to evolve. This is due to the differential nature of the pathological lesions involved.

MANY FACTORS other than poor diet can cause the development of a deficiency state in the body tissues. Such factors might be classified simply into external and internal causes. Examples of external causes might be an inadequate diet which is the simplest and most common cause; or disease of any sort, as almost every non-nutritional disease affects the nutrition of the patient. Internal causes might be any condition that would upset the normal process of the nourishment of the tissues by increasing the requirement for or by upsetting or distorting the usual pattern of digestion, utilization, and excretion of a nutritive essential.

It is particularly important to realize that the discovery of a deficiency in the tissues does not reflect merely the dietary habits of the patient in the recent past, or even the results of disease or metabolic disturbances of any kind in the recent past. These evidences of a deficiency present in the tissue may reflect a deficiency incurred at any time during that individual's life. Therefore, it is apparent that, especially in the chronic states, advanced deficiencies are more likely to be found with middle-aged or older people, merely because the greater time

NEWER KNOWLEDGE OF NUTRITION

element involved means that much more time in which a deficiency might occur.

Another important consideration brought to light by these studies is that therapy given in dosages which have been considered adequate in the past is not very effective when measured by actual cure of the lesions in the tissues. Kruse has found that for therapeutic purposes large amounts of the vitamins must be given. Effective therapeutic doses are usually about four to five times as great as the recommended daily maintenance requirement. This means that it is practically impossible for a deficiency to be cured by food alone. The essential factors are present in food in too small amounts to be effective therapeutically. Even if large amounts of certain foods were taken with this end in view, the extremely small curative effect which might theoretically be present would not be of much benefit to the individual, because he just could not live long enough for the accumulative effect to become noticeable. This raises the question of the value of self-treatment of suspected deficiency states with the low potency concentrates that are available to the lay person. It would also explain the many negative results obtained by physicians who treated suspected deficiencies for a short time with concentrates. Because no improvement was immediately noted, therapy was discontinued and the condition left unimproved. These are two of the cardinal points established by Kruse's work—that very large doses are necessary for therapeutic purposes and that therapy must be continued over a long period of time for complete recovery, particularly if the deficiency is chronic in nature.

THE MAJORITY of subjects who have formerly been tested by these new methods have been from low-income families. It was felt highly desirable by Dr. Kruse that a group with a different educational and economic background be tested

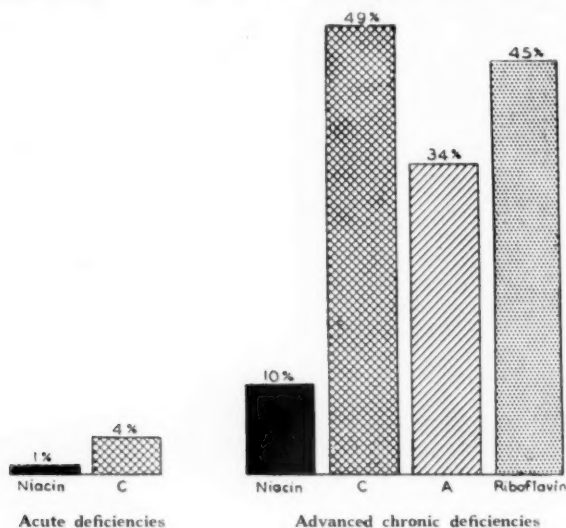
for comparative purposes. With this point in view, 198 nurses of the staff of the Henry Street Visiting Nurse Service volunteered to take tests to determine their nutritional status in regard to four vitamins—vitamin A, vitamin C (ascorbic acid), and two members of the vitamin B complex, riboflavin and niacin. This meant examinations by a biomicroscope of the conjunctiva of the eye, the gums, the cornea of the eye, and the tongue, respectively. The hemoglobin of each subject was also determined by means of a photoelectric colorimeter (Evelyn's method).

These nurses are accepted on the staff of the Henry Street Visiting Nurse Service after a pre-employment examination. From then on, they have annual physical examinations by two physicians chosen carefully by the organization, and all recommendations made at this examination are followed up by the personnel department. Thus, presumably, each nurse is in good health and capable of doing hard, physical work. She is exposed to considerable nutrition teaching, as there is a nutrition consultant on the staff, and an organized nutrition program. Presumably, then, each subject has also a good, up-to-date, working knowledge of the science of nutrition.

THE RESULTS of the tests on the nurses are most interesting. Practically all members of the group showed evidences of some chronic deficiency of all the vitamins tested. Vitamin C deficiency was found to be the most prevalent, as well as the most severe deficiency present. Forty-two percent of the nurses showed marked advanced chronic deficiency and 7 percent showed very marked advanced chronic deficiency. Fifty-two percent showed subacute deficiency changes and 4 percent evidence of an acute deficiency. The test for niacin deficiency showed that 10 percent of the group had changes due to an advanced chronic deficiency and 20

PUBLIC HEALTH NURSING

NUTRITIONAL DEFICIENCIES AMONG 198 PUBLIC HEALTH NURSES



percent those of a subacute nature, 1 percent of an acute deficiency. Fourteen percent of the group showed evidence of an early marked chronic deficiency of vitamin A and 34 percent of a marked advanced chronic deficiency, but only 2 percent a subacute condition. And in regard to riboflavin, 45 percent showed evidences of an advanced chronic deficiency, while only 2 percent a subacute condition. The percentages of those showing the more serious advanced conditions, the acute changes and the advanced chronic changes, are shown in the chart. Also, very significantly, when 12 grams per 100 cc was taken as the standard for normal hemoglobin values, 27 percent of the group fell below this standard.

The results found in such a group should arouse deep concern over those members of society less fortunate educationally and economically. These results support the facts found in all dietary surveys—that large numbers of the population in this country are not eating enough of the foods known to be essential for good health. They also explain the poor

correlation formerly found between the results of such dietary studies and the small prevalence of recognizable deficiency diseases.

This study adds to the growing body of evidence that the deficiency diseases are apparently prevalent among all levels of society. Now that they can be easily diagnosed and the degree to which they have progressed can be accurately determined, a new weapon is in the hand of public health workers. This weapon can be very effective in shortening the distance between the scientific knowledge available today of the benefits optimal nutrition can bring to the human race, and the public's present acceptance and application of these facts.

TODAY the term "good nutrition" has a broader meaning than ever before. Now that we have at our disposal methods so sensitive that they can detect any deviation from a practically perfect nutritive condition of the tissues, good nutrition means practically perfect nutrition. And now that we can study the effect that

NEWER KNOWLEDGE OF NUTRITION

specific conditions have upon the nutritive state of the body, we can appreciate the fact that many deficiencies may be caused by factors other than food.

However, all this additional information merely emphasizes a fact well known to public health workers, that an ounce of

prevention is worth many pounds of cure. The daily food we eat from infancy onward is still by far the most important single factor in nutrition. We must emphasize to all the importance of getting the right foods in the right amount every day.

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Comment on Miss Dwight's Article

FOR A GROUP such as ours at the Henry Street Visiting Nurse Service the kind of study now in process has immediate advantages, and from the point of view of staff education it is certainly stimulating. One is bound to have one's interest heightened and consequently one's information increased more by actual participation than by other means of learning. Each person included in the study cannot help but be concerned with the significance of the findings as they relate to herself. Consequently she develops an intimate knowledge of nutrition which might otherwise remain somewhat ac-

ademic. Enthusiasm gained through personal experience is a quality which usually becomes reflected by the persons exposed to the enthusiast. In other words, we expect to become better teachers of nutrition as a result of our experience with Dr. Kruse.

A group of public health nurses, particularly in an organization having the advantages of association with a full-time nutrition consultant, should be better informed than the average citizen. The sickness rate of our nurses is higher than that of the "average" worker. Perhaps we can hope through becoming better ac-

PUBLIC HEALTH NURSING

quainted with our nutritional condition as a group, as well as individuals, to elevate our health status to a point where we will be increasing our nurse power in these times when every day is precious. And just as important, we hope that we as individuals can become happier persons because we feel better generally. If we can do this we shall feel better qualified to pass on what we have learned, as well as what we already know, to other workers.

From the point of view of the nurses who are giving their time to this project the advantages are obvious. Those who are selected to be included in the follow-up group after the original diagnosis will be given therapy in a form which is expected to bring them up to optimum nutritional status as far as certain vitamins

are concerned. Those who have been diagnosed but not included in the therapy group will have a statement of Dr. Kruse's findings. This they may present to their personal physicians.

How "malnourished" can an individual be before there are effects in her feelings of physical well-being or in any impairment of her efficiency? We believe it should be interesting to compare the diagnosis of each person against her own opinion of her general health as well as against the opinion of her associates. The scientific value of compiled results for such a small group of people may be questionable. However, it seems it must be of interest to add such data to the rapidly accumulating material in the nutritional field.

—MARY FOSTER, R.N.

NURSE PLACEMENT SERVICE



announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom, consent to publish these has been secured in each case from both nurse and employer.

PLACEMENTS

- *Helen L. Woodworth, director, Visiting Nurse Association, Pasadena, Calif.
- *Mrs. Margaret D. Frantz, educational director, The Instructive Visiting Nurse Association, Baltimore, Md.
- *Elizabeth Vanden Bossche, supervisor, Illinois State Department of Public Health, Springfield, Ill.
- *Tressa B. Walters, assistant supervising nurse, Illinois State Department of Public Health, Springfield, Ill.
- *Mrs. Ethel DeMartin, county nurse, District of Blythe, Riverside County Health Department, Riverside, Calif.
- *Mrs. Virginia E. Bergstrom, county nurse, Pierce County Health Department, Tacoma, Wash.
- *Mrs. Alice Swanson Athey, industrial nurse, American Stove Company, Harvey, Ill.
- *Mrs. Helen E. Schack, temporary industrial nurse, Eversharp, Inc., Chicago, Ill.
- *Florence Edner, staff nurse, State Board of Health, Jacksonville, Fla.

ASSISTED PLACEMENTS

- *Ruth Fisher, assistant director, National Organization for Public Health Nursing, New York, N.Y.
- *Marjorie Tucker, assistant to director, Nursing Service, American Red Cross, North Atlantic Area, New York, N.Y.
- *Charlotte Eaton, nursing consultant for Vermont, American Red Cross, North Atlantic Area, New York, N.Y.
- *Florence Virginia Illing, chief nurse for Crittenden County Health Department, Arkansas State Board of Health, Little Rock, Ark.
- *Mrs. Eunice Lindgren Vandervoort, staff nurse, Division of Public Health, State of Colorado, Denver, Colo.
- *Mrs. Josephine W. Koch, staff nurse (*war emergency capacity*) New Britain Visiting Nurse Association, New Britain, Conn.

*The N.O.P.H.N. files show that this nurse is a 1942 member.

Teaching Nutrition with Pictures

By

BRUNO GEBHARD, M.D.

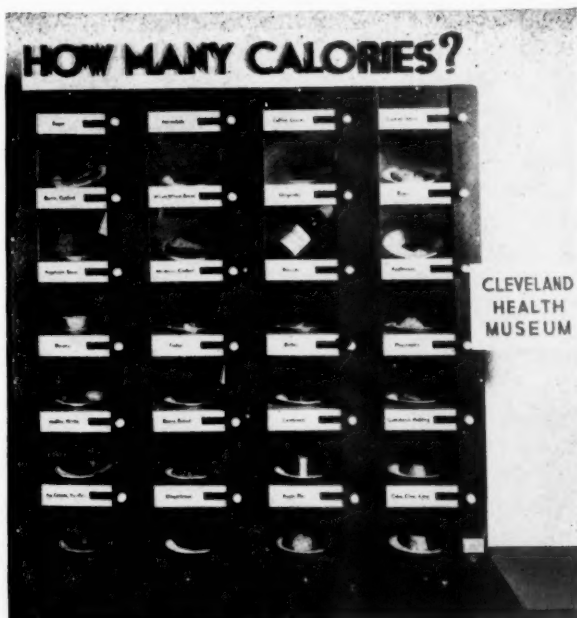


Figure 1. Food Automat

SOMEbody has said that the problem of how to feed the nation in war-time has four different aspects. There are first, people who don't know enough, second, those who don't grow enough, third, who don't have enough, and last but not least, who do not care enough. In health education we have to deal only with the first and the last groups, and we might add the group of those who know too much—but have not the right facts. Modern superstition in food fallacies is enormous and everybody seems to have his pet peeve against some foods which do not agree with him or her. On the other hand, we do not have to worry about motivation—everybody wants to enjoy his three meals a day. Eating is and should be fun. People are sensitive if somebody comes along and—what they think—spoils their meals. We are in nothing else so deeply rooted as in our food habits.

The so-called new nutrition is very easy

to sell. It does not ask for complicated food-formulas; it is no more expensive than the way most of the people have spent their food dollar. In World War I people got accustomed to the word "calories." The question now is whether they will learn the importance and meaning of "protective foods." What are the facts behind the new terms? Agreement on basic facts is the first necessity in a successful educational campaign.

We are very fortunate that we have something to go by in the "Recommended Dietary Allowances" of the Committee on Foods and Nutrition, National Research Council.* Those have been published in many different journals and are something that everybody who has to teach nutrition should know as well as he knows the multi-

*See "Recommended Daily Allowances for Specific Nutrients." *Journal of the American Medical Association*, June 7, 1941, p. 2601.

PUBLIC HEALTH NURSING

plication table. The tentative goal set up by these standards can be met by a good diet of natural foods.

It is not necessary to teach how many units of one of the vitamins one needs or how many grams of calcium or milligrams of iron. To the people we must talk in terms of foods, that is what they buy and eat. The general public is only interested in how to select and how to prepare foods which will satisfy its appetite, preserve its health, and stay within its financial means. Therefore instead of saying, "An adult woman, moderately active, needs 60 grs of protein, 0.8 gr calcium, 12 mg of iron, so many 1,000 units of vitamins of the different varieties," we say, "Include in your daily meals so much milk, two or more servings of fruit (one a citrus or tomato), potatoes and at least one other vegetable, one egg, one serving of meat or fish, bread and butter, and as much additional food as needed." Such a diet would fulfill the requirement of what has been called a "balanced diet"—a term which does not mean very much. It has been suggested that we use the more pictorial term, a "colorful diet." The general use of this term would stress the inclusion of yellow citrus fruit, or red tomatoes, the green leafy vegetables, the dark bread. Dr. Lydia J. Roberts in "The Road to Good Nutrition"* presents excellently what she calls the "nutritional yardstick." She tells about "basic foods" to insure proteins, minerals and vitamins, and "additional foods" to meet energy needs and to satisfy appetite.

THE definition of the right terms to be used in nutritional education must come first before one can even attempt to translate them in pictorial form or make them useful for education of the general public. Today the thinking of most people

centers around calories and vitamins. Knowledge of the first has become quite general since World War I, but typical of how misunderstood is this term is the following written inquiry—similar to many hundreds we get at the Cleveland Health Museum during the year: "How many calories are there in a pound?" This question demonstrates the confusion in many people's minds. Commercial advertisements have added to that confusion. They have also created a craze for vitamins, giving too many people the impression that these are the only really important food elements.

The British Council for Health Education has coined very pictorial and easily understandable terms for proteins and vitamins. The British talk about foods in such groups as these: "body workers and warmers," meaning carbohydrates and fats; "body builders," the proteins; and "body protectors." In the last group they include all dairy foods, fish oils, salads, vegetables, and fruits. Up to now it has not been possible under the English system to tie up point rationing with the nutritional value of the foods. Unfortunately it is the law of supply and demand which decides whether a food will have a high or low point value. For England especially the transportation facilities are and will be the most decisive factor.

Nevertheless, point rationing—on which system we in the United States are soon to embark—is an excellent starting point for nutritional education, against straight rationing as for coffee and sugar. "Point rationing" is "a system of rationing a group of related or similar commodities which can be substituted for one another in actual use." It gives each individual a chance to decide for himself how he wants to spend his share of points. It will train the housewife not only to budget her money, but also to give more consideration to the nutritional value of what she buys with her valuable "points."

*Children's Bureau Publication No. 270. Superintendent of Documents, Washington, D.C., 1942.

NUTRITION EXHIBITS

For some readers I may have dwelt too long on the importance of basic foods and the need for the use of right and understandable terminology. As the public health nurse has a very great responsibility in making the new knowledge available to a large number of members of the community, it is to be hoped that everything possible will be done to make available to her special training if needed and teaching aids to make her task easier.

UP to a year or so ago, pictorial means in nutritional education had been widely used for the most part only by commercial organizations. It is natural that those exhibits have included not all the foods but chiefly those in which the sponsoring organization was most interested. The Cleveland Health Museum now has available a traveling exhibit, "Food for Health," consisting of 15 units. These have been shown in more than two dozen places, in several different states outside of Ohio.

In designing these exhibits we combined the factual data as stated in the above mentioned recommended dietary allowances, with the answers to those questions most commonly asked by visitors. Dr. Helen Mitchell from the Office of Defense Health and Welfare Services, Dr. Helen Hunscher of Western Reserve University, and Mrs. Alice Smith, nutritionist at the Cleveland Health Council, have closely cooperated in this entire project.

The main units of this series are the exhibits "How Many Calories" and "Protective Foods." The first is constructed as a food automat (Figure I) and the visitor has to turn a knob in order to find out how many calories there are in average servings of favorite foods, such as two biscuits (100 calories), 1 tablespoon of butter (100 calories), or a piece of apple pie (330 calories). Closely connected with the "Calorie Automat" is the exhibit called

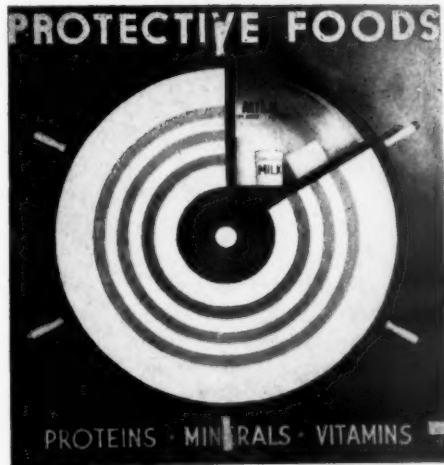


Figure II. Protective Foods

"Protective Foods" (Figure II). This exhibit gives in concentrated form the main points of the present recommended food groups for good nutrition. Under the title, "Eat Every Day," six different sections within a circle are covered by a steering wheel. This wheel has to be turned by hand, showing at a time only one of the six sections in which wax models demonstrate the suggested foods.

PROTECTIVE FOODS (Eat Every Day)

Title	Models
Milk—1 pint adult, 1 quart child, daily	Bottle of milk, can of milk, piece of cheese
Fruits—Two servings daily	Tomato, orange, can of applesauce, can of tomatoes
Vegetables—Two servings besides potatoes daily	Spinach, beets, beet tops, potatoes, and carrots
Cereals and Bread—At least 2 servings daily	Flour (enriched), whole wheat bread, whole grain cereal
Eggs—3 or 4 a week	Eggs, peas, and beans
Meat—1 serving daily	Liver, salmon, steak, pork chop

The "Food Automat" and the "Protective Foods" exhibits are connected by a sign reading, "Then fill in according to choice."

According to the principle that people's questions have to be answered first, an eight-foot-long exhibit with many models

deals with the most common food fallacies. This is another question and answer game. Triangle-shaped covers have questions listed as "Is it safe to eat acid fruits and milk together?" or "Is it safe to leave foods standing in open tin cans?" Other questions deal with the use of soda in cooking, the subject of brain foods, digestibility of eggs, and so on. The answers are hidden under the covers and can be read only by pulling the covers.

More in the line of biological education are a group of four manikins showing the foods which supply us with calcium, iron, protein, and vitamins. By pushing a button a transparency shows the bones and teeth, the heart and blood systems, the muscular systems. Vitamins are represented as giving vitality.

Specially for showing in schools and industrial plants are the exhibits, "A Nickel's Worth" and a giant "Lunch Box" (Figure III). "A Nickel's Worth" compares the nutritional value of a pint of milk and a soft drink, milk giving twice

the amount of calories, calcium, iron, and protein and Vitamins A, B, C, and G. The four last items mentioned are all absent in soft drinks.

Specially designed for the education of industrial workers is the exhibit "Your Lunch Box." An enlarged (8 feet by 4 feet) open-front lunchbox shows in wax models three adequate selected lunches for heavy workers and three suggested selections for white-collar workers.

The special tie-up between marketing and food value is shown in an exhibit called "Double Your Food Value for Less Money." This shows two filled market baskets.

Market Basket I contains in wax models:

- 1 1/4 lb. whole grain cereal
- 1 1/4 lb. whole wheat bread
- 1 lb. peanut butter
- 1 lb. hamburger steak
- 1 bunch carrots
- 1 bunch beet tops
- 1 tall can evaporated milk with Vitamin D
- 1 lb. margarine with Vitamin A
- 1 tall can tomato juice



Figure III. The Industrial Worker's Lunch

Market Basket I contains

- 1 lb. refined cereal
- 1¼ lb. white bread
- 12 oz. jelly
- 1 lb. lunch meat (bologna)
- 1 lb. white turnips
- 2 stalks celery
- 2 small cans pineapple juice
- 1 lb. lard

A sliding device permits only one basket to be seen at a time. In full view above the baskets all the time, a colored chart shows the amount of protective foods in terms of percent of daily requirement received by wise, or not-so-wise, buying.

Constituent	Basket No. I	Basket No. II
Calories	40%	27%
Protein	70%	22%
Calcium	57%	20%
Iron	95%	20%
Vitamin A	100%	0.6%
Vitamin B ₁	68%	10%
Vitamin B ₂ or G	62%	3%
Vitamin C	100%	73%

This exhibit is also a good demonstration that the new nutrition costs no more than what most people are accustomed to spending anyway. Before the rise of food prices, each basket represented one dollar's worth—as of January 1, 1943, the good

market basket cost \$1.43, the poor selection \$1.63.

There are several other exhibits in the traveling exhibit. Two of these have general interest. One shows the needed calories per hour for work and play and for the many activities of the housewife. "Food Building Blocks" are specially designed for classroom use. The empty blackboard is used as a background, and blocks in six different colors—the colors denoting water, minerals, vitamins, proteins, fat, and carbohydrates—give the composition of whatever food is to be demonstrated. For example, milk is the most complete food showing all six, sugar is the most incomplete showing only water and carbohydrates.

The role of nutrition in preventing disease and in building the resistance of the body against infections has been recognized by the medical profession. The bacteriological era in public health which has brought us such enormous progress in the control of communicable diseases is going to be succeeded by a nutritional era which will help in the promotion of the family health of all the people.

NEW OCD NURSING BULLETIN

Available soon is "Nursing Participation in the Emergency Medical Service," Bulletin 6 of the Medical Division of the Office of Civilian Defense, now in press. This will be welcomed by all nurses who are endeavoring to participate effectively in plans for the care of civilians injured by enemy action or other war hazards. The organization of the OCD is described, also state and local defense councils. The part of nursing in each is carefully defined. What nurses are to do in the Emergency Medical Service—in field casualty units, casualty stations and receiving hospitals, in the care of patients in

their homes—is outlined in some detail. Emergency base hospitals, nursing service in reception areas, first aid training for nurses, distribution and use of blood and plasma, and chemical casualties are among other important topics covered. One section is devoted to discussion of volunteers' contributions to this program, both professional and nonprofessional. Says the Foreword, nurses should "... be able to answer the questions of their patients and the public concerning these activities. As disseminators of information, nurses share the responsibility for public morale."

Responsibility of the Nursing Profession in Industry

By J. W. CROSSON, M.D.

IN RECENT years quite an impressive mass of literature has accumulated on this subject. Much of it consists of "oughts" and "shoulds," but, with few exceptions, the "hows" are omitted. It is suggestive that the literature containing the bulk of the practical "hows" was written, not by physicians or by governmental health experts, but by nurses with a substantial public health background and a knowledge of the fundamental problems of health in industry. I wish to repeat here some of the "shoulds," and attempt a few of the "hows."

First it seems appropriate to define the objective of nurses and physicians in industry. Simply stated, their objective is to preserve and improve the health of the worker. Note that emphasis in this statement is upon use of the words "preserve" and "improve" connoting emphasis on prevention.

Physicians and nurses with little or no public health training consider themselves concerned primarily in the treatment of disease, but inspection of our communicable disease statistics will show that more and more of the time of both professions is being devoted to the prevention of disease. In order to attain the ultimate objective of medical workers in industry our attention must be concentrated on prevention of occupational disease, prevention of accidents and conservation of employee health. The urgency of industrial production for the successful culmination of this war is the highlight

of today's news. It is our task to prevent interruption of productive capacity due to illness or injury from occupational and nonoccupational causes.

ABSENTEEISM AND ITS CAUSES

Among industrial workers the major causes of disability and ill health are not the illnesses and injuries incurred on the job. These account for much less than 10 percent of the total time lost from work as a result of disability. Less than 1 day of the 9 days' lost time from work incurred every year by the average worker is due to occupational disease and injury. More than 8 days' lost time is due to non-occupational disease and accidents.^{1, 2}

The great volume of industrial absenteeism results from the common diseases and accidents of which you and I, as well as the industrial worker, may be the victims. The incidence of these diseases, however, is much greater in the so-called working people than in other groups. It has been estimated that disabling illness is 76 percent higher among unskilled labor, and 40 percent higher among skilled labor than in the so-called nonindustrial groups.³

One of the most serious bottlenecks in the present war effort is absenteeism in industry. The diseases and disability brought about by toxic substances account for only a small part of industrial absenteeism. Accidents and injuries incurred on the job and at home account for only a little more than that due to

NURSING IN INDUSTRY

toxic exposures. Many of our acquaintances in industry are too ready to lay the blame for the major portion of absenteeism to the "Monday morning illness," due to weekend excesses. The two most common causes for absence in industry include none of these. The common respiratory infections and the gastro-intestinal disturbances are the chief offenders. You are all aware that the medical armamentarium includes no specific weapons to combat these categories of human illness, but the tremendous toll exacted by them in industrial absence can be sharply curtailed. This curtailment can be brought about by the dissemination of information concerning these diseases, by emphasizing the importance of personal hygiene, by instruction in proper and adequate nutrition and by improving the conditions of the working environment.

Other factors to be reckoned with in health in industry are mental health or mental hygiene, communicable diseases in the factory or mine and its environs, sanitation, nutrition, housing, and personal hygiene. All these must be considered in addition to factors in the prevention of occupational disease arising from lack of or improper control of gases, vapors, fumes, dusts, excessive temperatures, and humidities, from deficient lighting, noise, overcrowding, and fatigue.

NURSE'S SPHERE OF USEFULNESS

But what does the expansion of that simple statement of the objective of medical workers in industry have to do with the responsibility of the nursing profession in industry? The apparent digression was premeditated and not accidental. Some nurses in industry may still hold the opinion, as many physicians do, that her sphere of usefulness begins and ends in the plant dispensary. In large establishments with a full-time physician the activities of the nurse usually are somewhat limited, but even here she can find many

opportunities to become aware of the general industrial environment, to teach safety and health, and to suggest resources for helping the worker meet his problems. The nurse in the so-called small plant with 500 workers or less, and with little or no direct medical supervision will soon find considerable time on her hands if her activities are limited to the dispensary. Management usually discovers this situation also and requires the nurse to do clerical work, or to attend the plant telephone switchboard, unless she can prove the activity in her own field will be of greater value to workers and employer. At the present time the nurse cannot look to the physician for assistance in such a situation, because, with few exceptions, the part-time or "on-call" physician is still practicing industrial medicine on a curative or therapeutic basis, rather than accepting the opportunities presenting themselves in the field of preventive medicine.

Before an attempt is made to solve her problem it will be advisable to review the functions of the nurse in industry, to repeat a few of the "oughts" and "shoulds." The industrial nurse deals with a community of gainfully employed workers. She bears a large part of the responsibility for their health and welfare. Although her activities are guided by the policies and facilities of plant management, rather than those of a private nursing organization or a state or local health agency, she is in fact a public health nurse engaged by industry to care for the health and welfare of a specific industrial community. She is a specialist in the field of industrial nursing just as surely as the physician who devotes all or most of his time to industrial medicine. In order to practice industrial medicine successfully it is necessary to acquire a public health viewpoint, which is entirely different from that of the physician or nurse in ordinary

PUBLIC HEALTH NURSING

practice. The activities and efforts of industrial nurse and physician should be directed more toward the practice of preventive medicine, rather than toward curative or therapeutic medicine.

MEDICAL PLANT EFFECTIVENESS

The effectiveness of a plant medical program is not measured merely by the number of medical and surgical cases visiting the dispensary. A large number of such cases frequently indicates a failure of the medical and safety services. Dispensary visits for periodic physical examinations, check-ups on corrected defects and for consultations on personal problems affecting employee health, furnish indirect evidence of the effectiveness of a plant medical program. Direct evidence is furnished by a reduction in absenteeism, by lowered compensation and insurance rates, by increased efficiency and production, and by a more cordial employer-employee relationship.

A tentative report prepared by the U. S. Public Health Service in cooperation with the National Organization for Public Health Nursing lists 14 functions or responsibilities of the nurse in industry⁴ a few of which are discussed here.

Every industrial nurse should become thoroughly familiar with the various industrial processes in the plant, the occupational hazards and the various methods used for their control. In the small plant where little or no direct medical supervision exists, and where no engineering control program is in effect, a thorough sanitary survey can be undertaken by the nurse. Simple survey forms⁵ will enable her to make an intelligent sanitary survey, even though she may lack technical knowledge of medical and engineering phases of industrial hygiene. Such a survey will frequently result in the elimination of sources of unpleasantness and ill health, often overlooked by the physician and by management. In addition, the

nurse will have the opportunity to familiarize herself thoroughly with the working environment of each individual which will be valuable firsthand knowledge that can be applied to the possible relationship of a future or existing disability. The frequent appearance of the nurse in the plant gives the employee a sense of her familiarity with his problems, and increases his readiness to talk with her concerning them. She can then correlate disability with fatigue, worry, mental strain, friction in the plant or home, and observe other possible causes of disability or absenteeism which otherwise would never come to her notice. Also, a nurse who is familiar with the safety and protective devices provided can often throw her influence on the side of their adoption and proper use by the workers.

One of the greatest contributions the nursing profession can make in industry lies in the field of physical examination of workers. The nurse should stimulate the practice of pre-employment and periodic examination, and should encourage the worker to request physical examinations voluntarily when warranted. Successful efforts in this direction can be accomplished only when the nurse has gained the confidence of the employee and when he is assured that physical examination is not used as an implement of discrimination, or elimination, by management.

CORRECTION OF DEFECTS

A large part of the value of a physical examination is lost to both employer and employee if the medical staff fails to encourage correction of physical defects. Too often the worker leaves the examining room or returns from the physician's office believing he is in good physical condition merely because he has been accepted for employment. In the small plant with a part-time or on-call physician, the nurse is in a strategic position to render invaluable service to the worker

NURSING IN INDUSTRY

and to plant management by calling attention to defects observed during the course of the physical examination and by urging correction of these defects at every opportunity. In addition to increasing the employee's economic stability, his period of usefulness to himself, his family and the community, the correction of so-called trivial defects will reduce absence due to nonoccupational causes, which accounts for over 90 percent of industrial absenteeism.

Here is another field in which the nursing profession should assume a large part of the responsibility. Again, this applies almost entirely to the small plant, because most large industries have become acutely aware of this bottleneck that obstructs the flow of production. Most managers of small plants maintain that absence among their employees is negligible, but this is pure guesswork unless the absence records can verify it. If absences of one day or longer are not recorded, the nurse should attempt to work out some system of absence recording. Carefully-kept records of industrial absenteeism will frequently bring to light conditions in the plant, the home, or the community that might seriously affect the health of employees if permitted to continue. In this way, too, the absence-prone employee will be brought to the attention of the nurse. Such individuals are frequently struggling with some problem that can be solved by an interested industrial nurse who is thoroughly familiar with the policies of her company, with environmental conditions within the plant, and with the facilities available in the community.

These are a few of the responsibilities assigned to the nursing profession in industry. For a more complete and formal list you are referred to *Public Health Reports*, May 30, 1941, p. 1135.⁴ Study of this list will suggest to many nurses in industry various methods for discharging

those responsibilities. The nurse in industry should be stimulated to increased and more effective activity when she realizes the importance of those responsibilities, and how vitally essential it is to discharge them effectively, especially at this time. In a number of instances, perhaps, these duties will appear very difficult and almost impossible of achievement, not because the nurse is incapable of their execution, but because such activity is viewed with indifference or with distaste on the part of management. For these and others interested in extending their activities, two "hows" will be suggested.

HELPS FOR INDUSTRIAL NURSES

For further information concerning the sanitary survey report form, the mechanics of setting up an effective absenteeism recording system, for technical advice concerning real or suspected toxic exposures in the plant and for interpretation of various legislative measures affecting those in industry and many other problems, the industrial nurse can apply directly to the bureau of industrial hygiene in the state health department where such a bureau exists.

The second source of assistance available to the nurse in industry is the public health nurse attached to a private or governmental agency. It should be noted at this point that such assistance will be mutual. By offering her assistance and the facilities at her disposal to the nurse in industry, the public health nurse will gain entrance to and experience in a field that has been almost wholly neglected by public health personnel. That field might be called adult hygiene, or adult health education. The success of child health education and the control of communicable and other childhood diseases is now almost an historical fact. Efforts to attain this success were concentrated in the school—the place where most children could be reached. The problems and the

PUBLIC HEALTH NURSING

relationships in the industrial plant and mine are somewhat different, but the principle is the same. A huge segment of the population is conveniently located for the dissemination of health information and for the reception of advantages of public health and preventive medical procedures of proven value.

COMMUNITY RELATIONSHIPS

The first step in the development of this field, as far as the nursing profession is concerned, is a closer relationship between the public health nurse and the nurse in industry. It is logical that the nurse in the public health agency should make the initial advance. She should make certain that she knows every industrial nurse in her area and that each one is familiar with the services and assistance that can be rendered through the local health agency. The public health nurse should make certain that her colleague in industry is aware of the existence and use of all community agencies for securing psychological, social, and economic adjustments that may be needed for the worker and his family. She can assist the nurse in industry with health education of the employees in such fields as venereal disease, tuberculosis, cancer, nutrition, and personal hygiene. And with the advent of large numbers of women in industry, the field of maternal and child hygiene will assume an important place in health education in industry.

In some cases the public health nurse can visit the homes of disabled or chronically-ill workers if such service is not extended by plant management. Individual lessons in health education and home nursing care can thus be offered to

a group not ordinarily reached by the public health nurse.

The public health nurse should also use her influence to elevate the sanitary and nutritional standards of restaurants and lunchrooms located near industrial plants. It is not reasonable to expect safe and efficient work from an employee who breakfasts on coffee and doughnuts, especially if this food is served in establishments with low sanitary standards. The National Research Council has recently issued a bulletin outlining the extent of this problem and offering suggestions for its solution.⁶

PART-TIME NURSING SERVICES

That part of the nursing profession associated with private or nonofficial nursing organizations, such as the visiting nurse association, has a definite responsibility at this time. Such organizations should make every effort to enter the field of part-time nursing service to small plants.^{7, 8} In a survey by the U. S. Public Health Service it was revealed that only 33 percent of gainfully employed workers have access to some sort of nursing care while at work.⁹ Most of the employees so cared for were in large plants.

In summary, an attempt has been made to define the objectives of medical workers in industry. A few of the responsibilities assigned to the nursing profession in industry were discussed. Finally the importance of the public health nurse in the field of industrial health was outlined. Interest and increased activity on the part of the nursing profession in the field of industrial health is now, more than ever, of paramount importance to our nation's welfare.

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AUXILIARY WORKERS

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Auxiliary Workers in Public Health Nursing Agencies

IN BOTH official and nonofficial agencies the use of volunteer and paid auxiliary workers is increasing. The National Organization for Public Health Nursing has been asked for suggestions about recording the services of such workers and accounting for expenditures incurred because of their work. To aid in answering these inquiries eight members of the Cost Analyses and Records Committees met for joint discussion of these problems, and other members sent in their comments on the deliberations of the eight by mail. This brief summary of the opinions of the majority of the members of both Committees is offered to agencies planning to use auxiliary workers. The Committees limited their discussions to 1943 plans.

Some of the questions discussed at the Joint Committee meeting were:

1. How to enter visit data of the auxiliary worker on the day sheet, and on the patient's case record
2. How to count visits made by auxiliary workers
3. What to charge pay patients for visits made by auxiliary workers
4. How to account for expenditures incurred because of the use of auxiliary workers

The following comments and recom-

mendations were expressed in relation to these questions:

1. For the entries of visit data by the auxiliary worker on the day sheet, the use of a separate day sheet for the auxiliary worker was recommended. Of course, if the auxiliary worker accompanies the nurse, the nurse should take credit for the visit on her day sheet. But if the agency wishes to keep a complete count of visits of the auxiliary worker, the use of a separate day sheet for the auxiliary worker will make this possible. The auxiliary worker will indicate on her day sheet those visits in which she accompanies the staff nurse.

It was suggested that data written by the auxiliary worker about a patient may be placed on the back of the worker's day sheet and later transferred in the office to the patient's record. If the agency has a simple morbidity record form, the agency may prefer to have the auxiliary worker write her data directly on the record. In either case the nurse responsible for the patient's care would approve or discuss with her the data written by the auxiliary worker.

The discussion group considered that the decision about what kind of service the auxiliary worker could render in the

(Continued on advertising page 13)

Teaching Nutrition at Home

By GLADYS COOK, R.N.

The volunteer can help teach proper food choice and preparation to those tired mothers who do not read or go to classes, who must be shown—in simplest terms

WITH THE ADVENT of war, the nutrition conscience of our people was aroused almost overnight. In every community refresher courses for prospective nutrition teachers were offered and these teachers in turn taught Red Cross courses to all who came. But in spite of this accelerated activity, very many tired mothers of little children were left out.

In order to succeed in bringing up a stronger people, the knowledge of nutrition must be brought to the families of every social and economic group. The socially-favored attend nutrition classes but the mothers in undernourished sections of the population tend to stay at home. If they are to have the advantage of the newer knowledge of nutrition, it must be taken to them. The failure to meet the needs of less favored groups among our people has long been recognized by public health nurses. This story of nursing and lay cooperation in family teaching is presented with the belief that difficulties confronted here can be similarly tackled elsewhere.

The problem in Mrs. Van's family is typical. At the time the nurse arrived, Mrs. Van was preparing lunch for the three school children who would soon be home. She was warming over dumplings and gravy left from the canned stew of the night before. When the nurse suggested buying the meat and vegetables

and preparing her own stew, Mrs. Van said the canned stew was cheaper, not realizing how little meat she was getting for her money. Also, she was buying canned vegetables for the baby instead of preparing them herself and having some for the other seven children. This method also seemed cheap to her, and she forgot that often the older children went without any vegetables at all.

A similar case is that of the Adams family where the doctor had requested a nursing visit because five of the children and the mother had sore throats. He felt that poor nutrition was one of the reasons why they were always having colds. On her arrival the nurse saw Mrs. Adams preparing a lunch of bread and gravy for her brood and suggested a cabbage salad as a good and nutritious addition to the lunch. Mrs. Adams' comment was that they had never had it and besides cabbage was expensive! These seemed all-sufficient reasons why they should never have it.

Such problems seemed overwhelming to the nurse, for she alone could never hope to give the intensive and frequent supervision that these mothers needed. Soon, however, the opportunity for getting help presented itself to the county supervising nurse through her association with interested lay people in the county Nutrition Committee.

After several informal preliminary dis-

NUTRITION AT HOME

cussions, the supervising nurse called a meeting of a volunteer nutrition teacher, the department of welfare worker, and the public health nurse. At this meeting a fairly complete picture of the Van family was given as an example. The nurse told something of the family's eating habits and helped to guide the budgeting and general planning by the group for them. A plan was set up whereby a series of nutrition lessons would be given in Mrs. Van's home by a qualified volunteer teacher. Mrs. Van would ask a small number of friends and neighbors to join the class.

THE selection of Mrs. Ressler as our volunteer was a favorable one for she had been the home bureau foods leader for several years and had recently completed the refresher course given by the nutritionist of the state department of health. She had a real interest in people and some understanding of their problems. However teaching in the home was so different from anything she had done in the home bureau that it was some time before she had the courage to venture into the new field.

In this connection it may be well to remind nurses that although they are accustomed to going into all types of homes and feeling at ease with all kinds of people, this is not true of everyone. Nor has it always been true of nurses themselves. People in general do not go into their neighbors' homes, introduce themselves with the purpose of assisting in the affairs of the family.

Finally, the day came when our volunteer was ready to make the initial visit. The family was ready also, for while Mrs. Ressler had been preparing herself for home teaching, the nurse had been preparing the family. On the first visit the nurse went with the teacher to help her get acquainted, but after the first few minutes the nurse's services were unneces-

sary as the two women right away got on well together. Teacher and pupil made a beginning by looking at the flour bag to see that its contents were enriched and by discussing the family's likes and dislikes in the way of food. Soon the pupil was sharing some of her favorite recipes with her instructor.

In choosing a home for the classes, the nurse had selected this one because Mrs. Van is a responsive person and meets people easily. She is a second generation Italian, her husband an American of many generations. She has eight children ranging in age from one to sixteen years. Mrs. Van herself is a thin, undernourished-looking woman with a deformity due to bone tuberculosis, now healed. The children are all undersized and have low resistance to colds. They live in a two-family house with three rooms on the ground floor and two above. The kitchen is of fair size and the lightest room in the house. For the class, Mrs. Van had as her guests a quiet little neighbor and her daughter, also another neighbor with her daughter. Not all came to every lesson as the mothers and daughters had to take turns and one family moved away before the course was completed.

In order that the classes might not be a financial burden to anyone, the Town Health Council paid for the necessary supplies. Sometimes the teacher brought her own utensils, and at other times she used what Mrs. Van had. As a guide the nutrition teacher used the seven-lesson plan prescribed by the New York State Nutrition Committee and Cornell University. This was not slavishly followed. The lessons were made very practical, taking into consideration the family's eating habits and its resources, a part of which are surplus commodities. At one class the teacher demonstrated corn meal for the main dish with a sauce made from hamburger steak, onions, and tomatoes. Never before had the families had corn meal cooked in any other way than as

PUBLIC HEALTH NURSING

mush. In the demonstration, the teacher always made enough for the entire family and in each instance they liked the new dish. Because the family are fond of pie, the mother makes mince pies, four at a time, and pie is an expected part of their daily diet. Consequently, at one class Mrs. Ressiger made one from graham cracker crumbs with a filling of evaporated milk and lemon juice. Such a pie has several advantages over Mrs. Van's—is more nourishing and more digestible.

Families of the poor too seldom combine foods. They eat potatoes plain boiled and meat fried or boiled but always served in the same way day after day. To introduce a pleasing combination and a variety in the menu, at a later class Mrs. Ressiger made a baked dish of corn, cheese, eggs, and milk.

One of the encouraging results of the experiment was Mrs. Van's interest. As soon as she saw the can of corn, she darted into her pantry and brought out a can of her own. A comparison of prices revealed that hers was a cent cheaper. Her interest gave the instructor an opportunity to go into the matter of the different preparations of corn such as whole kernel and cream style. Another good sign was the fact that this mother did remember some of the teachings of the nurse. The day they had lamb stew with carrots, Mrs. Ressiger suggested that she could mash some of the carrots for her year-old baby. "Oh yes," replied Mrs. Van, "the nurse told me that." Perhaps not so flattering to the nurse was Mrs. Van's inquiry regarding other foods for the baby, in spite of the fact that the nurse had visited the home regularly and discussed diet many times. The teacher came back to the nurse for literature and suggestions. It must be remembered that campaigns of all kinds are won by getting as many people as possible all saying the same thing. Therefore, Mrs. Ressiger's advice sought by Mrs. Van provided the repeti-

tion valuable in the process of learning. The most encouraging sign of all, however, is the enthusiasm with which the family has accepted the volunteer teacher. The children call her the cook lady and vie with each other in carrying her packages to the car. They even stop her on the street and ask her to come oftener.

THIS experiment has many values apart from nutrition. Anticipation of a visitor is a real incentive to clean house. We can hardly blame a tired mother if she becomes careless about tidying her home which is bound to be in disorder again as soon as the flock of children troop in. Mrs. Van always had her home scrubbed and in order on class day. There is also a social value. Mrs. Van, like so many mothers of large families, never goes out; her whole life is bounded by the four walls of her home. It is a god-send to such a woman to talk over her problems with another homemaker who has interests in common. Moreover, not all the benefits accrue to the pupils. The teacher, too, has her vision broadened, her attitudes changed somewhat, and her understanding deepened.

At the present time there are several homes waiting eagerly for just this type of teaching. Now that so many people have finished the required twenty-hour course set up by the Red Cross, we are looking forward to having enough teachers.

The state department of health nutritionist has met with the nutrition chairman, two prospective teachers, and the public health nurse to discuss future plans. The nurse made suggestions from her observations in the homes. Both the nurse and the teacher will be on the alert in order to meet the needs of individual families. We feel sure we are working in the right direction when we take our nutrition classes into the homes where

(Continued on page 109)

The Nursing School Goes to the Community

BY M. RUTH SMITH, R.N. AND MARGARET E. NEWMAN, R.N.

There was a need, they met, took action—this in short is the story of an experiment in community service in which nursing students also were able to play a part

THE PUBLIC HEALTH nurse has well been named "catalytic agent," as she influences her patient in the home to carry out scientific health practices and particularly as she stimulates and takes part in inter-agency cooperation for better community health. There are many channels for this interchange of information and planning. There are the formal educational programs and policy-forming committees in large communities and the informal group meetings of scattered workers in rural areas. It is of this latter way of doing and a program initiated by nurses that we wish to report. In fact, a subtitle for this report could well be "A Community Action Committee and Its Influence upon the Hospital and School of Nursing."

Working in Clearfield County, Pennsylvania, are four State Department of Health nurses, three school nurses, two Red Cross nurses, and one nurse with the Clearfield County Tuberculosis Society. The population of Clearfield County is 92,094. There is one hospital with a school of nursing located here. Just over the county line, but a part of Clearfield community, is another hospital with a school of nursing. This hospital has an outpatient clinic service.

The public health nurses of the county,

the staffs of the two schools of nursing, and the supervising nurse of the outpatient service first met informally 16 months ago to discuss their programs, services, and activities. They have been meeting regularly since that time. The purpose of the meetings is to learn how much or how little each agency knows of the others' contribution to community nursing, and how their resources can be coordinated.

When social agencies working in the county have come into the group, this spontaneous growth has enriched immeasurably the content of the conferences. The juvenile probation officer of the County Court was the first non-nurse to join. She wished to perform her duties in cooperation with the agencies whose responsibility is the citizens' health. A child welfare worker (rural extension unit) and a supervisor of special education, attached to the office of the county superintendent of schools, were brought in. A district medical officer in a recently created district health unit under the State Department of Health was also added. The group conferences provided a means of orientation for these services, some of which were new. Representatives attended from the Department of Public Assistance, which covers aid to dependent children, blind and old age pen-

sions, general relief clients. The Children's Aid Society with its children's home, the Child Health Committee, a WPA project sponsored by the State Medical Society, and a social worker of the Erie Diocese of the Episcopal Church were included.

A questionnaire was used to register the wishes and needs of all, both in matters relating to programs and to such details as contribute to satisfactory participation by the members. The informality of the conferences extended to the place of gathering which has moved from place to place. The presiding officer has been the field supervisor for this area from the Bureau of Public Health Nursing of the State Department of Health. Minutes of all meetings have been sent to the group and these records have become a valuable source of information concerning agency activities. Meetings have been held on Saturday mornings—the most convenient time for the majority.

ALL conferences were packed with interesting information concerning the activities of the agencies represented. As group after group reported, the need for a central index in the community for clearing all cases handled by all agencies became evident. A subcommittee formed to study the feasibility of such a plan devoted three meetings to it. It met with the heads of local community fund organizations with the thought that such a project could be sponsored by these organizations. Plans were formulated to develop this index on a countywide basis. A speaker from a nearby city with experience in establishing such an index described the success of their plan, and a member who had just returned from a visit to Detroit reported on the plan there.

The spontaneity and enthusiasm that characterized this interchange of thoughts, ideas, and working plans were indeed refreshing. To the mind of a director of a school of nursing in the community who is also responsible for the nursing service

the value of these cooperative relationships can scarcely be overemphasized. A comprehensive understanding of community health and welfare resources has influenced both the nursing service in the hospital and the educational program of the school of nursing immeasurably. The objectives set forth in planning these meetings have been more than realized.

To a director of nursing service interested in community welfare, the problem of the ward service patient who returns home from the hospital with no plan for continuing his health program has until the present time just remained a problem. Hospitals with well-organized outpatient departments and urban areas with community nursing services can simply refer patients to these organizations, but where no organized facilities exist the problem becomes much more complex. A project organized by the group to meet this need has helped to solve many problems connected with the nursing service and the educational program of the nursing school. It has furnished facilities for teaching community nursing to the students lacking until this study was made.

The more tangible outcomes from the group-planning just described are:

1. Arrangements have been made for a form to be filled out for each ward service patient when he is discharged from the hospital. This form contains the address, diagnosis, date, and name of family or staff physician. It is sent to the office of the local Red Cross nursing service which sends a public health nurse to visit the home. Any referrals to other agencies that may be necessary are made; health teaching is done or nursing care given, depending upon the situation; a plan is made for the patient's future. Thus hospital treatment is not nullified after the patient returns to his own environment.

2. A 30-hour course in "Social Problems and Community Nursing" is being given to student nurses in the third year as a

direct result of this cooperative planning. The course is conducted by an instructor, and members of 18 local health and welfare agencies take part in the instruction, each one explaining the work of her organization in relation to the others. The course has been given twice and will be given again soon. It has been an important factor in helping to prepare two groups of nurses to understand their professional community responsibilities.

3. A successful plan for teaching self-care to diabetic patients by student nurses is a specific outcome.

4. In connection with their course in communicable disease nursing all students are receiving experience in the state venereal disease clinic held each week.

5. Plans are being formulated whereby the students will get valuable experience in the state tuberculosis clinic.

6. A general integration of community

health and welfare activities with those of the hospital has been secured which should be a valuable community asset.

7. Plans for a central index have been initiated.

8. A channel for the establishment of working relationships with all new services added to the county and area was established.

9. Common understanding of the functions as well as types of cases carried by all social and health agencies has been accomplished.

10. Firsthand knowledge of state agency resources has been fostered through representatives of the Bureau of Mental Hygiene, Council for the Blind, the medical care program of the Farm Security Administration, and the Division of Nutrition of the State Department of Health.

Nutrition Classes at Home

(Continued from page 106)

such training has been neglected and where the need is so great.

It is hoped that as our community organization grows such a program of home teaching will be developed in every locality as we know that similar situations exist everywhere.

To reach the people living under poor health standards, we must have a closely knit relationship between the nursing service, the nutrition committee, and other agencies. Such a relationship does not spring into being without thoughtful planning and cooperative work, and this frequently requires some time to produce results. For example, it was a matter of weeks before the volunteer teacher felt sufficiently confident of undertaking the home instruction, capable and eager to help though she was.

Certain safeguards are needed for such home teaching, and it is the nurse who can give the most valuable guidance. She explains to the lay worker the importance of attitudes, the treatment of confidential information, the consideration of individual family difficulties and assets. In many ways the nurse can help the teacher secure changes in family practice, while at the same time she builds up the confidence of the family in its own ability to manage.

Values other than nutrition, as such, are realized in such family work. Renewed interest and pride in housekeeping, social exchange, and mutual sharing of experience are among the advantages it was possible to bring to the Van family. Today each family is vital to our national effort in war. It is heartening to feel that these same families, strong and well, will be equally important in national efforts toward permanent peace.

Tuberculosis of Bones and Joints

By BECKETT HOWORTH, M.D.

JOINT TUBERCULOSIS is more common than generally supposed. Three hundred eighty-five cases of joint tuberculosis have been seen at the New York Orthopedic Hospital in the past five years. Great strides have been made in the past three decades in the recognition, prevention, and arrest of this disease.

Joint tuberculosis is always a secondary focus. Tuberculosis is caused by the tubercle bacillus, which usually gains entrance through the nose and throat by breathing or swallowing the droplets of a person infected with the disease, broadcast by coughing, sneezing, talking, breathing, or kissing. Germs may also reach the mouth by contaminated food or hands.

The infection first invades the lymph nodes of the lungs or mesentery, or the tonsils. It often lies dormant in the lymph nodes, but at any time may spread through the lymphatics or blood stream to almost any organ or tissue of the body. The lungs, kidneys, and joints are most commonly affected. The lung infection is likely to flare up after an attack of la grippe, pneumonia, whooping cough, or measles, or with malnutrition or fatigue. The tonsils have been found in some series of cases to be tuberculous in 25 percent of patients with joint involvement and probably are often a focus of joint infection. The incidence of joint tuberculosis has declined in recent years due to a reduction in the number of people with pulmonary or other foci of infection, but the war has caused the incidence to rise again in Europe and may soon do so in this country.

Joint tuberculosis is more common in

children than adults but may occur at any time from the first few months to the end of life. The joints are much more often involved than the shafts of bones, in a ratio of about 40 to 1. Multiple joint involvement occurs in 10 to 15 percent of these patients. The early lesion is the typical tubercle as seen elsewhere in the body, usually originating in the synovial membrane. The tubercle consists of a roughly circular area of young fibrous tissue cells, lymphocytes, a few giant cells, tubercle bacilli, and debris, in the midst of the involved tissue. As the tubercle enlarges, the central area of destroyed cells and organisms becomes purulent, later dry and "caseous," eventually shrinking and calcifying, leaving a cavity. The bone may be involved by hematogenous infection, or invaded directly from the soft tissues. The cartilage is not directly involved, but degenerates or is absorbed because of the adjacent circulatory and chemical changes. The joint fluid, whether synovia or pus, may contain tubercle bacilli. Gradually over a period of years the granulation tissue, synovial membrane, and cartilage become replaced by dense fibrous tissue, and a fibrous or bony ankylosis takes place. In the meantime the disease may erode the capsule, forming an abscess, and even the skin, forming a sinus. *Joint tuberculosis is never eradicated while there is motion in the joint.* Nature may eventually cure the disease by bony ankylosis.

SYMPTOMS

The symptoms of joint tuberculosis are pain, stiffness, limp (lower extremity),

BONE AND JOINT TUBERCULOSIS



Tuberculosis of spine—X-ray showing collapse of first and second lumbar vertebrae with disappearance of intervertebral disc and kyphos. Deformity has developed over a period of months and diagnosis should be made much earlier

and disability. Pain is usually not severe, often insidious in onset. It is often worse after activity, but may awaken the subject at night. It is usually a dull ache, but at times may be sharp and radiating. It may be intermittent or continuous, relieved by rest and by heat. Stiffness is due to pain, muscle spasm, and fibrosis. The patient notices difficulty in putting on his shoe, sitting or standing straight, or climbing stairs. The limp is due to pain, stiffness, weakness, deformity, or shortening. It may make difficult walking, running, work, or sports. Symptoms vary in degree with the duration and intensity of the disease.

The physical examination is likely to reveal deformity, inflammatory signs, limited motion, and a limp. The kyphos (knuckle or hunchback) is typical of spinal tuberculosis (Pott's disease). It

is due to destruction of the intervertebral disc and the anterior part of the adjacent bodies, but in the cervical or lumbar region the normal curve must flatten before the kyphos is visible. The characteristic hip contracture is flexion, adduction, and internal rotation, due to spasm and contracture. Shortening occurs, due to disuse, bone destruction, and contracture. The leg atrophies or fails to develop fully because of disuse. The inflammatory signs are redness, warmth, swelling, tenderness, and pain and spasm on motion. These signs are often mild, and hardly evident in the deep joints (hip and spine). Protective postures and motions are usually present. For example, the spine with Pott's disease may be supported by the arms when the patient sits.

Longitudinal section of thoracic spine showing erosion of vertebral bodies and intervertebral discs with collapse of spine, kyphos, and small abscess. Note spinal cord has not been compressed due to gradual development of deformity



PUBLIC HEALTH NURSING

Motion is limited in the early cases by pain and spasm, and therefore is better when the motions are tested slowly and gently. Limitation due to fibrosis is more definite and less variable while bony ankylosis results in complete elimination of motion.

LABORATORY AIDS TO DIAGNOSIS

Laboratory tests are useful in determining both the general and local condition of the patient. A negative Mantoux or von Pirquet skin tuberculin test, if properly performed, rules out the possibility of tuberculosis. The white blood count is not increased, whereas the proportion of lymphocytes is increased. The erythrocyte sedimentation rate is elevated to 50 or even 100 millimeters in one hour. Aspiration of the joint fluid may result in finding the tubercle bacilli in the centrifuged specimen, or in a positive guinea

pig test, although negative aspirations are inconclusive. Microscopic examination of diseased joint tissue obtained by biopsy or exploratory operation is the surest and quickest diagnostic proof of tuberculosis and should always be done if possible.

X-ray films are of considerable diagnostic value, but must be evaluated in relation to the other findings. Localized decalcification, narrowing of the joint space, and dense swelling of the joint capsule are characteristic. The decalcification is secondary to the circulatory congestion. Thinning of the cartilage causes the narrowing. The soft tissue swelling is due to joint fluid (often pus) and inflammation of the capsule. There may also be areas of actual bone destruction, cortical or cancellous. Such areas do not tend to cross the epiphyseal lines of children. Secondary infection causes condensation of the bone, especially at the



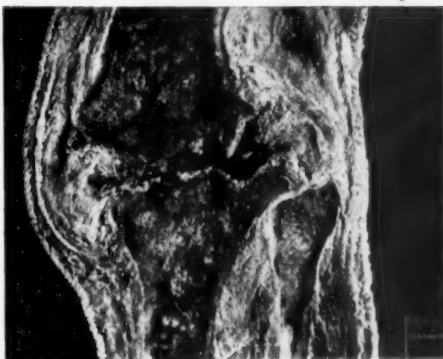
Tuberculosis of spine—kyphos in lower thoracic region with increased lumbar lordosis due to compensation. Diagnosis should be made and operation performed before this stage is reached

BONE AND JOINT TUBERCULOSIS

joint surfaces. The soft tissue swelling subsides in time and bony ankylosis, with trabeculation across the joint, may be seen. When ankylosis occurs the disease becomes quiescent and may even be eradicated.

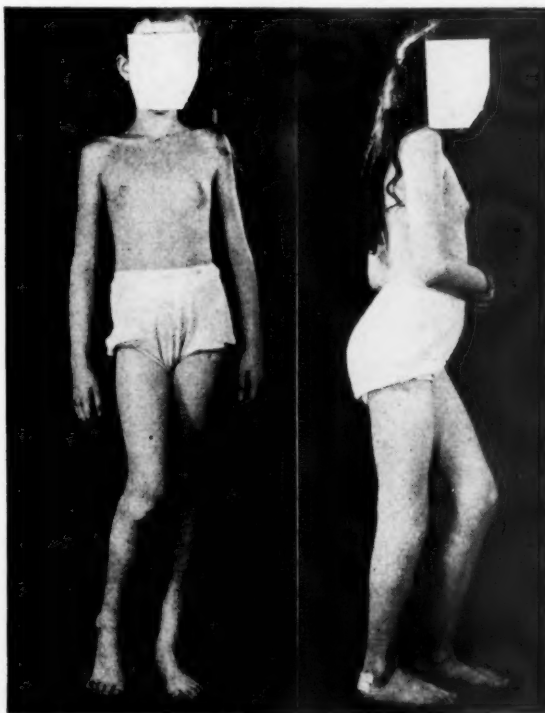
TREATMENT

The treatment of joint tuberculosis is the same in principle as that of tuberculosis elsewhere: rest of the joint; rest of the patient; fresh air, sunshine, good food, a pleasant environment, and occupational therapy for the patient. Foci of tuberculosis, such as tonsils, if infected should be removed or cured if possible. The joint may be rested on a firm bed, in a brace, Bradford frame, or plaster cast. Such treatment has been used for many years, often with improvement, but it is slow and uncertain. In the meantime many of the patients died of miliary tuberculosis, meningitis, amyloid disease, or exhaustion.



Tuberculosis of knee—longitudinal cross-section showing involvement of articular cartilage, synovial membrane, and adjacent bones

Russell A. Hibbs, in January 1911, did the first spinal fusion for tuberculosis, and the child recovered. This operation has since been done hundreds of times and the results have been far better than with previous types of treatments. The spinal fusion, which causes the laminae and lat-



Tuberculosis of right hip—typical flexion-adduction deformity, with instability of knee due to wearing cast and brace for many months

PUBLIC HEALTH NURSING

eral articulations of the vertebræ to grow together in one solid mass of bone, forms an ideal internal splint and gives nature its best chance of healing the disease.

The operative risk is small and is far less than the risk from the disease itself. The diagnosis can usually be proven at operation by microscopic examination of a frozen section of the involved tissues. The period of bed rest and hospitalization is reduced to a few months instead of years. The disease heals completely and gives no further trouble in the majority of these patients. Moreover, other lesions in the body often react favorably to the eradication of the bone focus. The fusion operation has been applied to all the major joints of the body, with results similar to those in the spine. The disability caused by the ankylosis is usually much less than the disability caused by the disease itself, and at the same time the danger of the disease and of further deformity is eliminated.

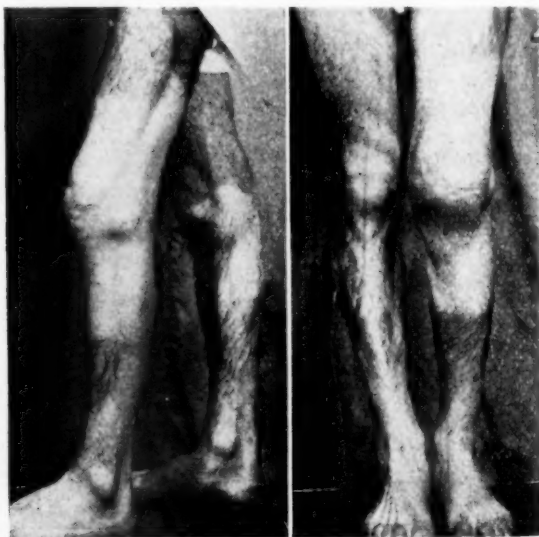
Bone tuberculosis without joint involvement is treated by excision of the diseased area and packing the cavity with bone chips from the tibia or ilium.

POSTOPERATIVE CARE

Postoperative care is of great importance and applies to the whole patient as well as to the local lesion. Bed rest for several months is usually necessary. The mattress should be firm and the bed flat, usually a fracture board. Constant and intelligent nursing care of the brace or cast is necessary—to prevent pressure sores, prevent damage to the cast, and to insure proper fitting and comfort of the brace. Sunshine and fresh air should be provided whenever possible. The diet should include sufficient calories, protein, vitamins, minerals, fats, and roughage. The patient should have enough time and quiet for sleep, after lunch as well as at night. His surroundings should be made as pleasing as possible, and his contacts if in a hospital, with other patients as well as the hospital staffs, should be agreeable. Occupational therapy is most valuable.

The progress of the healing joint is checked at appropriate intervals by clinical examination and by X-ray, and casts are changed at least every three months. Usually the second cast is a "walking

Tuberculosis of left knee—"white swelling," knee swollen, tissues thickened, veins dilated, slight flexion deformity



BONE AND JOINT TUBERCULOSIS

cast" and the patient is allowed up, but he must be watched very carefully for the next few weeks. After leaving the hospital he should return for periodic examinations, about once a month the first year and yearly thereafter.

PROGNOSIS

Uncomplicated joint tuberculosis should heal completely following a fusion operation. Sinuses present before operation are likely to persist for a long time, while those occasionally forming in the operative wound heal more quickly. Disability from the fusion operation is not great, particularly if the operation is done before deformity develops. Spinal fusion stiffens only the affected section, and often there is so much compensation in other areas that this is hardly noticeable. Hip fusion results in a slight limp and requires sitting at an angle, but it does not prevent running, dancing, or swimming. Knee fusion produces the most noticeable limp and this can be minimized by the clothing and by shorter steps. These patients can walk, run, swim, dance, work, and play almost as well as the average normal person with relatively little fear of recurrence.

PROPHYLAXIS

Reduction of tuberculosis in cattle to

less than one percent, coupled with obligatory pasteurization of milk in all cities, careful meat and poultry inspection, and proper cooking, have markedly lessened dietary sources of tuberculosis. The prevention of joint tuberculosis is now more frequently the prevention of primary infection in the lungs, tonsils, or mesentery by isolation or control of those with the disease, particularly of those in contact with children. Once infection has occurred somewhere in the body, it must be kept isolated and innocuous by following the rules of rest and hygiene for the tuberculous patient. Eventually joint tuberculosis will be eliminated as tuberculosis is eliminated from the population. Possibly some drug or method of immunization will be discovered which will cure or prevent the disease, or at least save the joint. At present the disease can only be eliminated by sacrificing the motion of the joint.

CONCLUSION

Joint tuberculosis is subject to precise diagnosis by clinical, laboratory, and X-ray methods in combination, but the final diagnosis is made from guinea pig inoculation or tissue biopsy. Joint tuberculosis can be permanently cured at present only by natural or operative fusion of the joint.

ACKNOWLEDGMENT

The January issue of *PUBLIC HEALTH NURSING* carried an article and table, "Industrial Nursing Personnel Essential to Maximum War Effort," without mention of the fact that the original data upon which this was based was collected and tabulated by the United States Public Health Service. Olive M. Whitlock, nurse consultant to its Division of Industrial

Hygiene, was chairman of the Committee to Study Duties of Nurses in Industry established by the Public Health Nursing Section of the American Public Health Association. The first draft of the table of industrial nursing activities was prepared by Miss Whitlock. The omission of this important information is sincerely regretted.

NOTES from the NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

ANNUAL MEETINGS

Unusual interest and good feeling marked the annual meeting on January 22 of the Board of Directors of the N.O.P.H.N. attended by 22 of 30 directors, from all parts of the country. Ernest L. Stebbins, M.D., commissioner of health of the City of New York, was elected to membership on the Board and Executive Committee. On January 21 the Council of Branches met in an all-day session. Eighteen out of 21 S.O.P.H.N.'s were represented. Reports of these meetings will appear in next month's magazine.

ORTHOPEDIC NOTES

Third in the series of orthopedic handbooks published by the Joint Orthopedic Nursing Advisory Service is the new "Orthopedic Conditions at Birth: Nursing Responsibilities" by Jessie L. Stevenson, now in press and available by the time this notice reaches you. First and second respectively are "Posture and Nursing" by Jessie L. Stevenson and "Orthopedic Nursing" by Carmelita Calderwood. All are free upon request. J.O.N.A.S. contemplates at least two more handbooks, one on the care of patients in orthopedic appliances and teaching of functional activities, one on staff education in orthopedics.

New assistant consultant in orthopedic nursing is Margaret S. Arey who joined the staff on February 1. Miss Arey's undergraduate preparation was received at Massachusetts General Hospital in Boston. She was a 1942 J.O.N.A.S. scholarship student finishing the approved course in physical therapy at Harvard Medical School in December. She was trained also in the Sister Kenny Method at the D. T. Watson School of Physiotherapy in Pitts-

burgh. Miss Arey replaces Mary M. Macdonald who returned to the Community Health Association in Boston in January.

The new Committee to Study Desirable Preparation for Nurses Specializing in the Orthopedic Field met February 5, with Ruth Heintzelman as chairman. The Committee will consider the need for changes in nursing education in this specialty to meet the new problems growing out of the war.

CONGRESS ON INDUSTRIAL HEALTH

Mrs. Christian F. Seabrook, chairman, Executive Committee of the Industrial Nursing Section, and Mary M. Dunlap, assistant professor of nursing education, University of Chicago, represented the N.O.P.H.N. at the Fifth Annual Congress on Industrial Health held in Chicago, January 11-13.

They reported that the program was stimulating and the papers presented were of high quality. Outstanding points of interest were: (1) the increasing emphasis being given to the public health and preventive aspects of the industrial health program in such problems as tuberculosis, venereal diseases, nutrition, care of the older worker, health problems of women workers (2) the importance of closer cooperation between the industrial medical department and the public health agencies in the community (3) the relation of the industrial health program and the community health program (4) the importance of the industrial nurse and her contribution (5) the necessity for delegating as many duties as possible to the nonprofessional worker under supervision of the nurse and physician (6) rehabilitation (7) health education.

N.O.P.H.N. NOTES

IN THE FIELD

THE VISITING NURSE SOCIETY OF PHILADELPHIA, PA., January 7—Ruth Fisher conferred with Mathilda Scheuer relative to the Council of Branches meeting held in New York City on January 21. . . . DISTRICT OF COLUMBIA SOCIETY FOR CRIPPLED CHILDREN, Washington, D. C., January 8-9—Jessie L. Stevenson conducted an institute on orthopedic nursing, discussing the normal body in rest and activity (illustrating body mechanics with Kodachrome slides) and orthopedic implications in nursing services. The institute began with an afternoon session on January 8, and Miss Stevenson conferred with the supervisors of the District of Columbia Health Department in the morning. . . . THE CATHOLIC UNIVERSITY OF AMERICA, Washington, D. C., January 11—Miss Stevenson talked to two classes of students on posture and nursing (showing the slides covering body mechanics) and public health aspects of orthopedic care—particularly, maternal and infancy services. She conferred with members of the faculty and administrators of the program of study in public health nursing regarding the inclusion of the orthopedic content of The Public Health Nursing Curriculum Guide in the postgraduate program. The needs of the community for nurses with some orthopedic preparation and ways in which the University might give assistance were also discussed. . . . THE INSTRUCTIVE VISITING NURSE ASSOCIATION OF BALTIMORE CITY, Md., January 12—Miss Stevenson talked at the joint meeting of the staffs of the I.V.N.A., the Baltimore City Health Department, and the Babies' Milk Fund Association, using slides to illustrate her remarks. She discussed the orthopedic implications in nursing care. In a conference with the director, supervisors, and orthopedic nurse of the Association she also gave advisory

service to the I.V.N.A. regarding their orthopedic program. While in Baltimore, Miss Stevenson stopped in at the sheltered work shop of the Maryland League for Crippled Children and found that where they had heretofore made braces and other orthopedic appliances, they were now engaged in doing work for local war industries. . . . WORCESTER SOCIETY FOR DISTRICT NURSING, Worcester, Mass., January 23—Miss Stevenson advised on the Society's orthopedic service. On January 25, she gave a talk on orthopedic implications in nursing care before the staffs of the D.N.A. and the City of Worcester Department of Health, receiving excellent publicity in the Worcester press. . . . FAIRFIELD VISITING NURSE ASSOCIATION, Fairfield, Conn., January 26—Mrs. Edith Wensley spoke at the Association's annual meeting, after lunching with the Board of Managers, on the subject of wartime adjustments in public health nursing agencies. . . . VISITING NURSE ASSOCIATION OF PLAINFIELD AND NORTH PLAINFIELD, N. J., January 27—Ruth Fisher participated in the annual meeting of the Association, in addition to giving advisory service to the V.N.A.

THANK YOU, SCRANTON!

A Good Gremlin directed the hand of headquarters' stock clerk to the cut of the seal printed at the top of the Contents page in January PUBLIC HEALTH NURSING. For many years this space has carried the seal of the N.O.P.H.N. This time by lucky mischance the seal of The Visiting Nurse Association of Scranton and Lackawanna County appears in the feature spot. We say lucky because all along we intended soon to mention the fact that the Scranton V.N.A. this year increased its dues relatively more than any other member agency.

Reviews and Book Notes

NUTRITION AND DIET THERAPY

By Fairfax T. Proudfit. 1069 pp. The Macmillan Company, New York, eighth edition revised, 1942. \$3.25.

This edition contains revisions of interest to public health nurses. Normal nutrition in pregnancy, during lactation, and for well children of different ages is given a special section. Practical application of the theory of nutrition is emphasized through guidance in meal-planning, marketing, and budgeting. Feeding the foreign-born and those on low income levels is discussed.

The basic principles underlying adequate nutrition are taken up in detail, including up-to-date information on the vitamins, which is well summarized in tabular form. However, the pictorial illustrations are quite drab.

Modifications of the normal diet for therapeutic purposes are given thorough consideration and are simplified by a summary table. The projects outlined at the close of each chapter would be suggestive for the teacher. Some of the recipes to be used in the laboratory classes need to be revised again to incorporate newer methods of preserving nutritive values when preparing food.

As a general text for nurses, this book is informative and inclusive.

DOROTHY D. HUDSON
Boston, Massachusetts

MANUAL OF WAR-TIME HYGIENE

By Dean Franklin Smiley, M.D., and Adrian Gordon Gould, M.D. 86 pp. The Macmillan Company, New York, 1942. \$1.

This little book is designed, in the words of the authors, "to provide a brief summary and bibliography of those materials which a college student should add to his regular college hygiene course in order that he may be equipped to meet his health responsibilities as an officer in

the Armed Forces or in Civilian Defense in the years immediately following his graduation." It succeeds in this purpose admirably. The three chapters present briefly but concisely the salient facts about Military Hygiene, Civilian Defense, and Wartime First Aid, and a two-page bibliography points the way to a more detailed study of varied phases of wartime hygiene.

The practical side of personal and community hygiene takes on a new and lively interest when the student learns of the health hazards of life in camp and at the front, and the meticulous care taken by the Army and Navy to safeguard the well-being of everyone. The programs of civilian defense and of first aid in wartime place a new value on health.

The Manual is designed as a supplement to *A College Textbook of Hygiene* by the same authors—now in its third edition. The Manual is in paper cover, well printed, and illustrated with charts and diagrams. Directions for artificial respiration are given in the Appendix. This handy little volume should be in the possession of every college student today.

LOUISE STRACHAN
New York, New York

HOW TO FEEL BETTER AND LOOK IT

By Frank T. Kimball and Abbott W. Allen, M.D. 280 pp. Duell, Sloan and Pearce, New York, 1942. \$2.50.

Because it is written in nontechnical terms this book would be of value in teaching lay people the importance of physical relaxation and good posture. The text emphasizes the latter and for this we are duly grateful. Thirty-nine pages are devoted to illustrating correct and incorrect posture positions at rest and in activities. Each page has about ten pictures. Diet, exercise, sleep, and symmetry of shape are other subjects discussed. The

BOOK NOTES

public health nurse who teaches lay people daily might find it interesting to study the method of approach used by the authors of this text.

MARY M. MACDONALD
Boston, Massachusetts

FAMILY NUTRITION

Published by the Philadelphia Child Health Society,
311 South Juniper Street, Philadelphia, 1942. 106 pp.
Single copies free.

For more than two decades, the Philadelphia Child Health Society has been promoting knowledge of nutrition as an essential part of the equipment of all health workers. This bulletin on nutrition for the family is another contribution from that organization made possible by a grant from the Beneficial Industrial Loan Corporation.

The results of the Pennsylvania studies in human nutrition are the basis for the assumption that economic status cannot be used as a gauge for knowledge of food selection. Malnutrition exists in all groups

of the population. A committee of physicians and nutritionists has assembled material intended to assist both lay and professional workers to plan programs in nutrition education. Two chapters are devoted to a resumé of the findings of the Pennsylvania investigators and other similar studies, and to the techniques used in measuring nutritional status. Consideration is also given to the nutritional needs of human beings and to the ways in which foods supply the necessary nutrients. The final section of the pamphlet contains samples from the educational leaflets available in quantity from the Philadelphia Child Health Society. They include food plans and menus for children at different ages and for families of various income levels.

The pamphlet is well illustrated and should prove helpful to public health nurses and others engaged in public health work.

ELIZABETH GUILFORD
New York, New York

RECENT PUBLICATIONS AND CURRENT PERIODICALS

NUTRITION

EAT RIGHT TO WORK AND WIN. Prepared by Swift and Company in cooperation with the Office of Defense Health and Welfare Services. Available from the Office of Civilian Defense, Washington, D.C., 1942. Free.

FOOD CHARTS: FOODS AS SOURCES OF THE DIETARY ESSENTIALS. Prepared by a Joint Committee of the Council on Foods and Nutrition of the American Medical Association and of the Food and Nutrition Board of the National Research Council. American Medical Association, 535 North Dearborn Street, Chicago, 1942. 20 pp.

FOOD FOR FREEDOM SERIES. Available from the Bureau of Home Economics, U. S. Department of Agriculture, Washington, D.C., 1942. Free. Fight Food Waste in the Home. Vitamins from Farm to You. When You Eat Out.

FOOD VALUE CHARTS. Available from the Philadelphia Child Health Society, 311 South

Juniper Street, Philadelphia, revised December 1942. 50c per set.

Calcium in Foods.
Iron in Cereals.
Iron in Foods.
Niacin in Foods.
Phosphorus in Foods.
Protein in Foods.
Vitamin A in Foods.
Vitamin B₁ in Breads and Cereals.
Vitamin B₁ in Foods.
Vitamin B₂ in Foods.
Vitamin C in Foods.
Vitamin D in Foods.

HEREDITY, FOOD AND ENVIRONMENT IN THE NUTRITION OF INFANTS AND CHILDREN. George Dow Scott, M.D. Chapman and Grimes, Inc., Boston, 1942. 778 pp. \$5.

A wealth of material in a good reference book.

THE FOOD AND NUTRITION OF INDUSTRIAL WORKERS IN WARTIME. Report of the Committee on Nutrition in Industry, National Research

PUBLIC HEALTH NURSING

- Council. Available from the Council's Food and Nutrition Board, 2101 Constitution Avenue, Washington, D.C., 1942. 17 pp. Free.
- TWO PAMPHLETS prepared by the Bureau of Home Economics, U. S. Department of Agriculture. Available from the Bureau, Washington, D.C., 1942. Free.
- 20 Questions on Enriched Flour and Bread.
- 99 Ways to Share the Meat.
- TWO PAMPHLETS available from The Nutrition Division, Office of Defense Health and Welfare Services, Washington, D.C., 1942. Free.
- Democracy Means All of Us: How Communities Can Organize to Study and Meet Community Needs with Special Suggestions for Developing Nutrition Programs in Wartime. 30 pp.
- The Food We Live By. Prepared by the U. S. Office of Education. 11 pp.
- VITAMIN VALUES OF FOODS IN TERMS OF COMMON MEASURES. Miscellaneous Publication No. 505, U. S. Department of Agriculture. Available from the Department, Washington, D.C., 1942. 29 pp.
- ### HEALTH EDUCATION
- A VENTURE IN PUBLIC HEALTH INTEGRATION. Columbia University Press, New York, 1942. 56 pp. \$1.
- The 1941 Health Education Conference of the New York Academy of Medicine. Good information for use in planning health education programs and community contacts.
- FREE AND INEXPENSIVE TEACHING AIDS. Compiled by Leslie W. Johnson. Educational Bulletin No. 5. Department of Education, Frankfort, Kentucky, 1942. 589 pp. 50c.
- ### WARTIME
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- SPECIAL BULLETIN SERIES prepared by the Women's Bureau, U. S. Department of Labor. Available from the Superintendent of Documents, Washington, D.C.
- No. 1. Women in Industry: Effective Industrial Use of Women in Defense Program. 1940. 22 pp. 10c.
- No. 2. Lifting Heavy Weights in Defense Industries: Methods for Conserving Health of Women Workers. 1941. 11 pp. 5c.
- No. 3. Safety Clothing for Women in Industry. 1941. 11 pp. 10c.
- No. 4. Washing and Toilet Facilities for Women in Industry. 1942. 11 pp. 10c.
- No. 5. Women's Effective War Work Requires Time for Meals and Rest. 1942. 4 pp. Free.
- No. 6. Night Work for Women and Shift Rotation in War Plants. 1942. 8 pp. 5c.
- No. 7. War Work: Hazards to Women Employed in War Plants on Abrasive-Wheel Jobs. 1942. 6 pp. 5c.
- No. 8. Farm Labor Guides for Wartime Use of Women on Farms. 1942. 11 pp. 10c.
- No. 9. Safety Caps for Women in War Factories. 1942. 4 pp. 5c.
- ### MATERNITY AND INFANT CARE
- MATERNITY CARE FOR WIVES OF MEN IN MILITARY SERVICE AND MEDICAL CARE FOR THEIR CHILDREN: Provided by State Public Health Agencies with Federal Maternal and Child-Health Funds under the Social Security Act. Children's Bureau, U. S. Department of Labor, Washington, D.C., October 1942. 7 pp.

NEWS

Highlights on Wartime Nursing

NEW SUBCOMMITTEE CHAIRMAN

Marion W. Sheahan was appointed February 1 as chairman of the Subcommittee on Nursing of the Health and Medical Committee, Office of Defense Health and Welfare Services. She succeeds Marion G. Howell who has retired as chairman. Miss Sheahan is director of the Division of Nursing, New York State Department of Health, first vice-president of the N.O.P.H.N., and a member of the Board of Directors of the National Nursing Council for War Service. She has been a member of the Subcommittee for the past year.

NURSING COUNCIL

To develop more effectively the participation of colored nurses in the war nursing program as a whole, the Council is organizing a new unit of service under the able guidance of Mrs. Estelle Massey Riddle. Mrs. Riddle will be assisted by a strong advisory committee with Mrs. Ruth Logan Roberts as chairman. Among problems facing the group are: recruitment of qualified Negro student nurses, sound growth of nursing schools, raising educational standards in existing schools, recruitment of graduate nurses for military service and other important assignments. The Committee seeks Negro nurse representation on all policy-making and advisory groups in national wartime nursing activities. Up to now, so far as time allowed, Mrs. Mabel K. Staupers of the National Association of Colored Graduate Nurses has assisted the Council in these matters. A grant of \$5,800 from the General Education Board now permits expansion of this program during the coming year with a full-time executive. Mrs. Riddle was director of nursing at the

Homer G. Phillips Hospital in St. Louis. Mrs. Roberts has held many important posts in relation to nursing. Recently the Y.W.C.A. celebrated her 20 years as a member of the National Board.

Edith H. Smith, formerly director of the Leland Stanford University School of Nursing and until recently, nursing consultant to the Health and Medical Committee of the Office of Defense Health and Welfare Services, will promote college recruitment for the Council. She will visit colleges in the eastern states to present the opportunities in nursing before undergraduates, deans, and vocational counselors.

STUDENT NURSE CORPS

The plan for a student nurse corps, recommended by a special committee of the N.N.C.W.S. and recommended with some changes by the Joint Committee of the American Hospital Association and the Nursing Council, has been approved in principle by the Subcommittee on Nursing, and details are in the process of being worked out. The plan would call for a Federal appropriation to enable student nurses enlisting under the plan to receive stipends as well as scholarships through the U. S. Public Health Service. Third year students—"cadet nurses"—would live outside and receive suitable compensation from the hospital.

STUDENT QUOTA—1943-44

Sixty-five thousand young women must enter schools of nursing between June 30, 1943 and July 1, 1944, if even minimum civilian and military needs of the nation are to be met, Paul V. McNutt, Federal Security Administrator, has announced. Determination of this quota, which ex-

PUBLIC HEALTH NURSING

ceeds the 1942-43 quota by 10,000, was reached at a meeting recently held here of the Subcommittees on Nursing and Hospitals of the Health and Medical Committee, Office of Defense Health and Welfare Services.

HOSPITAL AUXILIARIES

Responsibility for employing and training auxiliary hospital workers rests with the individual hospital, according to an agreement reached in Washington early in January by the Subcommittees on Hospitals and Nursing of the Health and Medical Committee, Office of Defense Health and Welfare Services. Some professional groups have contended that the Federal Government should assume at least partial responsibility for training, placing and subsidizing auxiliary workers in hospitals. The series of conferences held over a period of months to weigh all angles of the proposal culminated in final action at the joint meeting of these two subcommittees January 9.

ARMY-NAVY NURSE CORPS

Members of the Army and Navy Nurse Corps are to receive the same pay and allowances prescribed by law for commissioned officers of the same rank, according to provisions of the new pay bill signed by President Roosevelt the day before Christmas. These provisions include base pay of \$1,800 a year for nurses with the relative ranks of second lieutenant and of ensign; in addition they receive quarters, subsistence, and one issue of uniforms. The uniform issue will include everything that the nurse will need, whether she is sent to the tropics or to the Arctic regions.

The new law also provides increases for nurses in higher ranks and liberalizes allowances in all brackets. This increase, the second salary raise for Army and Navy nurses since the beginning of the war, provides a jump from \$1,080 to \$1,800 yearly. When war was declared, the members of the two nursing corps received only \$840 a year, plus full maintenance and issue of uniforms.

From Far and Near

- A founder, and for many years president of the Visiting Nurse Association of York, Pennsylvania, Anna M. L. Huber was presented with a life membership in the N.O.P.H.N. on January 27 by the Board of Directors of the York Association. This is a fitting honor to one who has served her community's and the nation's cause of public health nursing as well for fully thirty-five years. Miss Huber was one of the first to recognize the importance of the participation of the lay citizens in public health nursing problems, and gave unsparingly of her time in the development of a well-considered program for lay members of public health

nursing associations. She was a member of the Board of Directors of the N.O.P.H.N. from 1928 to 1932. Recognition from other agencies has been accorded Miss Huber. In 1924, she received the Pennsylvania District Medal for distinguished service from the Kiwanis Club; in 1932 a citation for outstanding service by a woman to the City of York, from the Business and Professional Women's Club.

- To meet the shortage of well-qualified health educators the Kellogg Foundation has made a grant of \$40,000 to the U. S.

(Continued on advertising page 8)

PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

The Older Public Health Nurse in the War Effort

BECAUSE OF the war this country is experiencing a growing shortage of man and woman power. In no professional group is the shortage more acute than among registered nurses. Hence now the attention of all who are responsible for securing adequate service in the Army and Navy, in civilian hospitals, and public health agencies is centered on ways of increasing the number of active nurses. It seems possible that public health nursing agencies may help a little with this problem by reconsideration of their personnel policies about the age of retirement.

Within the last ten years an increasing number of nonofficial public health nursing agencies have begun to make retirement plans for the nurses of their staffs. Partly, this action has been taken because most public health nursing associations, formed after the turn of the century, realized the problem when certain of their own staff members were no longer physically able to carry the full load of service because of advancing age. Perhaps an even more important factor in this interest in retirement plans was the passage of the Social Security Act in 1935 which provides for income on retirement of employees in other than nonprofit agencies but makes no provision for employees of such agencies as public health nursing associations.

Information collected by the N.O.P.H.N. in 1939 shows that most agencies who have given consideration to this matter decided on 55 years for staff nurses and 60 years for supervisors, as

suitable retirement ages. It has been the hope of these agencies that some sort of a pension plan might be developed through participation in governmental provisions or adoption of a group insurance plan by the agency, or both. Up to the present time, however, most agencies have gone only so far as to write the time of retirement into their personnel policies. This was at least one step in the right direction, since in this way employees are informed in advance and thus able to make their own arrangements for the time when they will leave the agency. Application of policies of this kind, doubtless sound and wise, before the war, perhaps should be placed in abeyance during the war period.

The Red Cross to a large extent has kept public health nurses on the deferred list and some local communities have not as yet felt sharply the lack of public health nurses. In other communities, however, a great need is already recognized and the need will tend to increase.

For the duration of the war it would seem sound practice that no public health nurse should be dropped solely because of age. Young nurses who would replace the older ones thus retired are needed in many places, while many older nurses are still able to render highly acceptable service in their accustomed jobs but would have great difficulty in securing new positions. No blanket rule, of course, can be applied but it now would seem wise to consider each individual carefully before she is dropped from the staff because of age. If she is still capable of satisfac-

PUBLIC HEALTH NURSING

tory service, even on a part-time basis, some plan for using her can perhaps be made which would release a younger nurse

for a public health nursing position in a crowded defense area.

—R. H.

Do Something About Salaries!

THE FOLLOWING letter recently addressed to the state director of public health nursing discusses a significant factor in the loss of public health nurses from official public health nursing agencies to the armed forces and to industry:

In view of the continued loss of public health nurses from essential health departments and the crippling of such health departments resulting, it seems to me that we should quit crying and start doing something.

The causes of this exodus are, of course, many but the shortage and loss are primarily due, it seems to me, to one thing—*Salary*. This is not an accusation of avariciousness on the part of nurses. It is a practical, realistic facing of facts. Whether we like it or not *salary bespeaks the value placed upon one's services*. And when public health nurses have had such a low value placed upon their services for so long (despite all the lip service and praise), it is only natural that more direct or obvious war work in industry or Army, with better salaries for less training and fewer hours of work, makes a stronger appeal because these services command a truer appreciation and a higher evaluation. The conclusions are obvious. If public health nursing is essential war work, then we must compete in salary with other essential work. Else the claim to essentialness rings as a hollow falsehood.

This is a golden opportunity to bring the salaries of public health nurses to where they should have been long ago. If we are

ever to interest enough persons in public health nursing we must get adequate compensation now. It seems to me we lack clear pronouncement on the part of our state and national leaders demanding adequate public health nursing salaries.

This is a time when we may be able and may be compelled to get adequate salaries for public health nurses on a local level. We may need financial help from the Federal Government, but it is up to the state and the U. S. Public Health Service and Children's Bureau to see that merit systems and red tape, and other state and federal impediments do not interfere with this effort. That is the least we should expect. I wish that we might look to those state and federal agencies for leadership and assistance in this matter. If we cannot have the active backing of state health departments and federal authorities, we ask, at least, their moral backing, in writing.

This is a crisis. Public health nursing is essential in essential war areas. For the duration, at least, we must have salary schedules in local official agencies that can compete with those in other essential public health nursing agencies.

May I request that you present the matter to the State Health Officer and to the federal nursing consultants and get a statement backing our effort to get public health nursing salaries raised in this vital area in order to stop the needless wasteful exodus?

—E. G. McGAVRAN, M.D.
COMMISSIONER OF HEALTH
ST. LOUIS COUNTY HEALTH DEPARTMENT
CLAYTON, MISSOURI

New York Plans for Emergency Public Health Nursing

By MARGARET G. ARNSTEIN, R.N.

How Emergency Public Health Nursing Squads are being formed and trained in the state to aid existing community nursing services in event of enemy action

THE EMERGENCY Medical Service has been organized to take care of war casualties in the civilian population. A large part of its activities will be concerned with caring for people injured during a raid, but it is expected that a certain number of minor casualties, not in need of hospital care, will be discharged to their own homes after treatment at a casualty station. Although the Emergency Medical Service will be responsible for the follow-up of these patients at home, through the use of Emergency Public Health Nursing Squads, in New York the organization and administration of this branch of the service has been delegated to the State Department of Health.

In the past when emergencies have occurred requiring additional public health nursing service in a given area the State Department of Health has been able to assist the local communities by assigning state public health nurses to this area temporarily. It was done during the floods in the summer of 1936, when all state nurses were moved from the northern part of the state to the stricken areas in the South, and it has been done frequently in large outbreaks of communicable diseases.

These emergencies were localized and could be adequately taken care of in this manner. However, in considering possible war emergencies, it was realized that the State Department of Health nursing staff might not be able to supply an adequate number of nurses for any widespread disaster. Therefore, a plan was devised at the request of the Emergency Medical Service to meet such a need.

RESPONSIBILITY

It was agreed that the State Department of Health should direct emergency public health nursing as the normal work of this department. Organized by districts, it is the logical agency to administer this work, and previous experience in supplying emergency public health nursing service makes it particularly well fitted to train and administer such a corps.

The Emergency Public Health Nursing Squads being formed will assist local public health nurses during an emergency in the following ways:

1. Give care to patients with minor injuries sent home after treatment at a casualty station.
2. Give care to patients evacuated from hospitals before complete recovery to provide room for new casualties.

PUBLIC HEALTH NURSING

3. Supplement local resources in the event of a widespread epidemic.

USE OF EXISTING SERVICES

The first step in meeting additional demands is to make sure that the existing nursing services are being used most efficiently. This may involve temporary readjustments to meet a particular emergency. If more than one public health nursing agency exists in a community, work of the various agencies must be coordinated. Nursing directors in cities and counties are now thinking of this type of community planning. For example, if the emergency is the type that increases the load of home nursing visits in a community with health department nurses and visiting nurses under a private agency, the visiting nurse association would be the normal recipient of such calls. The other public health nurses in this case would be assigned to work with the visiting nurse service and would omit their nonemergent home visits and certain clinic duties in order to make bedside calls. On the other hand, if the emergency is such that a large number of immunizations are needed, the visiting nurse service would assist the health department nurses at clinics and in making home visits. School nurses are included in the emergency nursing plans and use of their services is being worked out with the principals and superintendents involved.

EMERGENCY SQUADS

Emergency Public Health Nursing Squads are being formed to supplement these local services. Each squad consists of from two to four inactive nurses, practical nurses or nurse's aides, and in some areas other lay volunteers are being used. A public health nurse is in charge of each squad and will assign cases to her squad members and supervise their work. The personnel is secured from the nurse inventory and from volunteer files in con-

sultation with the nurse deputy of the local Emergency Medical Service.

DUTIES AND TRAINING

The following brief suggestions regarding duties and training have been prepared:

Duties

1. Members of squads will assist public health nurses in making home visits. As these are not trained public health nurses (unless retired public health nurses are available), the public health nurse squad leader should choose the type of case to be visited by the squad member.

If several members of a family need care, the public health nurse might take a nurse's aide with her to assist. These are the most suitable cases for nurse's aides, though they can be used in the care of chronics and convalescents if the public health nurse knows the situation very well. (Of course, in an extreme emergency every available person will be used to her fullest capacity.)

2. Squad members should report to the public health nurse in charge of their squad at the end of each day or more often if necessary. Calling physicians, social agencies, and others in regard to patients should be done by the public health nurse.

3. A simple record form will be supplied from the district office of the State Department of Health.

Training

Public Health Nursing Squads will be engaged primarily in public health nursing activities under the direction of the city, county, or district state health officer, or a nurse or agency designated by him, in cooperation with the chief of Emergency Medical Service. Therefore, it is the responsibility of the agency to assign a nurse qualified by training and experience to teach squad members.

Length of Instruction

All personnel assigned to Emergency Public Health Nursing Squads should have a minimum of four hours of group instruction and demonstration in addition to their basic training in nursing procedures.

Graduate nurses assigned to these squads should spend at least one day in the field observing the work of a public health nurse. Nurse's aides should care for at least five cases under close supervision. Suitable observation for all

EMERGENCY PUBLIC HEALTH NURSING

squad members will be arranged by the instructor.

After this initial training squad members should meet together at least every two months, and at this time activities of the public health organizations may be discussed or demonstrations of various types of home visits given.

A simple outline of material which might form the basis for discussion in these group meetings

has been prepared by the State Department of Health.

These Emergency Public Health Nursing Squads are only now being formed and group instruction is now in process in most parts of the state. Therefore, it is too soon to have any idea how satisfactorily the above plans will work out.

A Spoilt Party

IT WAS half-past twelve in a London school. There was an eager chatter of voices; small girls and boys wearing their best blouses and clean socks, were eating a special dinner before going to see "A Midsummer Night's Dream." There was a crash, a long crash. The matron of the neighboring London County Council Hospital looked out of her office window and saw a German plane flying low. They will need us, she thought, and went quickly to the casualty ward to see that hot water bottles were warming all the beds.

Before one o'clock ambulances were arriving at the hospital. The stretchers were mostly light for their burdens were small. Rosy, glowing bodies had become gray misshapen bundles, mouths were full of grit, eyes so swollen and dirty that they could not see. Young minds, thinking perhaps of Puck and Titania, of good food and drink, of the theater and Shakespeare, had been suddenly stunned. The beds in casualty ward were soon full, not with crying children, but with quiet, determined, young Britons, wondering, as they told the nurses, how mother would replace their torn and dirty clothes, and sorrowing rather that dinner had been disturbed and they had missed their "afters" than for their cuts and bruises.

TO SAFER AREAS

The hospital opened its gates. Mothers and friends came straight to the ward to reassure their children; some they found

in the mortuary, some were still buried under the ruined school. In all, 96 children came to the hospital, 30 went home after minor treatments, and 38, suffering from simple fractures and wounds, went in ambulances to country hospitals that afternoon. They traveled in clean gowns and socks, with washing consisting only of sponging of face and hands. A thorough cleaning could be done when they arrived and had recovered from shock.

The scene in the casualty ward was one of quiet efficiency. Every nurse and sister who would be spared was there, but there was no confusion. As the doctors went round, marking each child's paper for X-ray, morphia, theater, or evacuation, sister followed putting the words into action. Each child had an injection of anti-tetanus serum; many had oxygen with a B.L.B. mask and plasma or blood transfusion for shock or hemorrhage. X-rays were taken in the ward—75 in all—showing fractures of skulls, ribs, tibiae, fibulae, femurs, scapulae, olecranon, and clavicles. One girl had nine fractures; others had penetrating wounds, bits of metal from the shrapnel imbedded, and one had nine inches of wood deep in her buttock. The effects of blast were seen on almost all. The eye surgeon was busy helping to prevent future damage to sight; he stitched up one cornea and ordered many irrigations with undine and boracic lotion.

(Continued on page 131)

Nursing Service in a Local Disaster

By ELEONORA ALDRICH, R.N.

Early planning and rehearsal made it possible for the community and its public health nurses to go into quick and effective action when disaster actually hit home

CONDITIONS resulted in the Cattaraugus County floods of 1942 that closely resembled the results of bombing or sabotage. Because organizations are being developed to cope with enemy action, it seems worthwhile to review the actual functioning of the local nursing services at the time of this disaster.

Beginning shortly before midnight on July 17, 1942, a flood involved the whole southeastern portion of the County. It brought with it death, untold property damage, and completely interrupted public utilities. To cope with the resulting public health nursing problem, 14 public health nurses, 11 inactive registered nurses, 2 licensed practical nurses, 15 Red Cross nurse's aides and 40 Red Cross clerical assistants were needed during the three weeks following.

Questions most frequently asked regarding the part which nurses played were: What personnel did you use? How did you get them? How did the Office of Civilian Defense participate? Under whose direction did you function?

The accompanying map may help to make the picture clear. The County is situated in the southwestern part of New York State and has a population of about 73,000. It is largely rural. The Allegheny River, with its many tributary

creeks runs through the southern half of the county, where nearly half of the population lives. The river and its tributaries kept on rising until about 3 p.m. on July 19, when they had flooded the area indicated by the stippling on the map. Portville was isolated. Olean, a city of 22,000, was not only isolated from the outside world, but divided into four or five islands separated from each other. Bridges were out, gas and electric power were off, the telephone ceased to function in Portville and in some places in Olean, and finally the water systems failed.

EMERGENCY ORGANIZATION

The organizations primarily in charge of the work in the flood area were the American Red Cross, the Office of Civilian Defense, and the County Department of Health. Each had its particular functions and by close coordination the situation was handled with a minimum of confusion. The outline on the opposite page indicates the division of work.

The American Red Cross, of course, is designated to take charge in cases of disaster caused by nature, in cooperation with the established authorities. The responsibility for maintaining health then falls to the health department. A large part of the nursing in this instance came under the heading of public health nursing.

NURSING IN A LOCAL DISASTER

ing. Clinics for the administration of typhoid vaccine were established throughout the area. Evacuee shelters and a first aid station had to be staffed and, insofar as possible, a generalized public health nursing program had to be maintained.

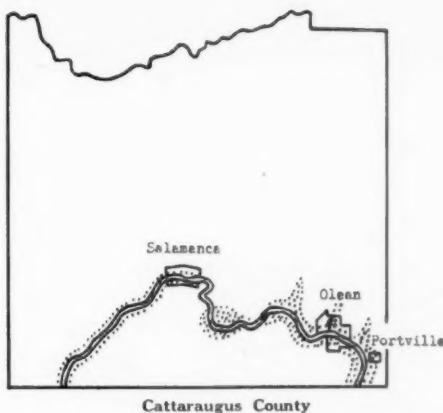
Nursing services as they existed in the flood area were:

Active nurses—institutional, private duty, office, public health nurses, American Red Cross, County Department of Health, school, industrial.

Inactive nurses—organized under O.C.D. as hospital emergency squads, casualty station nurses.

The nurses organized as hospital emergency squads are inactive nurses who are married but willing and able to help in the hospitals if needed. The list of casualty station nurses was made up of 6 health department nurses, 2 school nurses, 6 inactive nurses and 1 office nurse—assumedly able to respond instantly in case of war incident. The Red Cross had 2 public health nurses, the County 13—4 of which lived in Olean, the remainder near their work in other townships.

Thus, on paper, when the flood struck,



we were quite well supplied with nursing services. Actually, only two nurses were immediately available. Two in the flood area were by chance on vacation and could not be reached by telephone. Another nurse ventured out to locate the others with the help of the post warden of the civilian defense organization and a Coast Guard boat. The milk sanitarian living north of the flood area was asked to bring the public health nurse from that district with him to Olean.

Vaccination clinics could not be started

American Red Cross	Office of Civilian Defense	County Department of Health
1. Canteen service	1. Auxiliary police	1. Sanitation Water and sewage Milk Emergency chlorination Laboratory examination
2. Rescue and evacuation*	2. Rescue and evacuation*	2. Communicable disease prevention Program Clinics Physicians—public health and volunteer private Nurses—public health and volunteer Red Cross—nurse's aides and clerks
3. Transportation and communications	3. Communication center (local)	3. Survey and investigation
4. Registration and information	4. Emergency Medical Service Cots and blankets for shelters	
5. Supervision of shelters		
6. Medical aid First aid post Hospital care		
7. Staff assistance Nurse's Aides Clerical, etc.		

*Through a combination of American Red Cross, Office of Civilian Protection, and Coast Guard.

PUBLIC HEALTH NURSING

on Sunday, July 19, since it was getting dark by the time the vaccine requested from the State Department of Health arrived. Olean was without lights and the people's only thoughts were on rescue work. Affected were 2,750 houses; 1,395 homes had water above the first floor and 257 business places were flooded. Thousands were evacuated. The Red Cross Subcommittee on Medical Aid had assumed the responsibility for providing nursing services for their first aid station and shelters. They, too, depended largely on volunteer nursing assistance. Ill evacuees were sent to the hospitals.

On Monday morning, July 20, we public health nurses in the County Department of Health took stock of ourselves. Our well-known ability to improvise was called into action. The electric current was still off and our supplies in the office were limited. We began by collecting equipment into "units" which could be taken into the field and used in "emergency clinics." We had no way of judging where these would be. A water main had broken, the reservoir was draining into the river and gas had to be shut off in most sections. In the Portville area all public utilities were out of commission. Tripods and alcohol lamps were resurrected to furnish boiling facilities in the field. Towels were sterilized by baking in home ovens.

CALL FOR VOLUNTEERS

The radio had broadcast the clinic announcements and people responded amazingly well, far beyond our expectations. This resulted in a need for more personnel to help in the clinics. First of all, we checked the list of 15 O.C.D. casualty station nurses. We found that 3 were away, 1 felt her family more important, 7 (including the public health nurses) were otherwise employed. The remaining 4 were willing to help in the clinics whenever we needed them. In ad-

dition, 11 inactive and 2 practical nurses volunteered their services.

As we worked with these volunteers it became apparent that: (1) The emergency drills which had been held by the O.C.D. made for better cooperation. We all knew each other, and joint practice made for better personal rapport. (2) Good leadership is essential. In an emergency people are willing to follow direction, providing it is understandable and fair. (3) Working hours need to be adapted to the needs of the inactive nurse and the volunteer worker as usually she has other responsibilities. It is easier for a married nurse to give a few hours a day several times a week, rather than one or two full days.

In the County as a whole the generalized public health nursing program went on without interruption. In Portville local inactive nurses and volunteers assisted the public health nurse, and in Allegany a local inactive nurse took charge of the clinic, assembled volunteers, and was ready to assist the doctor when he arrived with equipment.

The question of volunteer clerical help for clinics at first presented a problem. Nursing committee members who usually staff clinics in normal times had other assignments in the emergency. The Red Cross was asked for assistance. One of their staff assistance corps was immediately put in charge of assigning clerical personnel on a regular schedule. Instructing the lay volunteers and supervising their work, however, remained the responsibility of the County Department of Health. In all, 40 volunteer clerks were used to staff the clinics for the three-week period.

Public health nursing demands increased and the Red Cross assigned 15 nurse's aides to help in the heaviest clinics—two at each session.

By Wednesday evening, approximately 10,000 persons had been vaccinated at

NURSING IN A LOCAL DISASTER

the clinics; several thousand more had gone to private physicians. Still crowds deluged us with requests for inoculations, so that every once in a while an unscheduled clinic had to be held.

SITUATION IN HAND

Monday, July 27, nine days after the flood, was the day set by the commissioner of health to give us an index of what to expect in the way of illness in the Olean and Portville areas. All the public health nurses set out at 9 a.m. to make a one-day survey to determine the prevalence of gastro-enteritis, each one assigned to a definite area in which she was to visit every third house. The survey showed the prevalence of this condition to be no higher than normal at this time of year. All of the nurses were therefore permitted to return to their districts.

By the end of the third week all immunizations had been completed and at this date it is possible to report that there was no typhoid attributable to the flood.

This is a sketchy picture only of the part nurses played in the disaster. We were far too busy to watch others, nor

did we have time to take over activities which could be done as well or better by some other agency. In this connection we were agreed on the following:

1. A system of coordinated services can be established with the smallest possible amount of waste effort if each organization renders the services assigned to it and no others.

2. No one can successfully serve two organizations simultaneously. This disaster proved that it was impossible to be active even on two committees since each demanded work in a different capacity and at a different place.

3. There must be a definite understanding of what each person's responsibility is within the organization. Only with this knowledge can he function effectively.

There is no doubt that the splendid organization of the Red Cross, civilian protection services, and others enabled them to operate as efficiently as they did. The cooperation rendered by these other organizations as well as private citizens was both inspiring and something to be long remembered.

A Spoil Party

(Continued from page 127)

Time passed unnoticed. The theater had extra tables; each case took a long time for all cleaning and washing was done under anesthetic. One small girl had said, "Please don't do anything to me without chloroform." It was 11 o'clock in the evening before the theater staff thought of a rest, and after an hour they started afresh.

In the small hours of the morning the emergency work was over. Every child from the theater or from the casualty ward had gone to her own bed in a ward. Plasma and salines were set up often in order to give sulphonilamide until the child could take it by mouth. The next day 12

more children went to the country and only 10, dangerously ill, were left in their own hospital with their mothers sitting by their sides.

Porters, doctors, floor women, nurses, and hospital officers of all kinds played their part in helping London's children shake off the dirt and damage of war. Not one of them heard a cry, a grumble, a note of distrust or distress—not even a whimper. Who can say of their own childhood that they faced pain and destruction in the same way? Many products of our civilization may be mean, illogical, and unimaginative, but we have a fine race of children.

—F.F.A., S.R.N., S.C.M.
In *Nursing Times*, JANUARY 30, 1943

Varicose Ulcer: Etiology, Treatment, Prophylaxis

By M. LAURENCE MONTGOMERY, M.D., AND
HENRIETTA M. MONTGOMERY, R.N.

IT HAS NOT been long since, in many clinics, the management of varicose ulcer was frequently associated with a sense of frustration because of the inability to obtain consistently good results. This state of mind is no longer necessary since the vigorous investigation of vascular disorders of the past 10 to 15 years has focused attention on ideas and procedures—some old and some new—which, when properly employed, will cure or keep in check the tendency toward ulcer formation. Much further progress can be made, however, particularly by the more widespread dissemination of this knowledge among the affected patients.

The public health nurse can be of signal service by assisting in this work. She can see to it that persons committed to her care, who are suffering from this painful, disabling disease, are fully acquainted with the benefits that can be obtained. She can assure them that, in the absence of acute infection of the ulcer, they need no longer remain idle at home, often confined in bed, but can be properly treated and returned to work while the ulcer heals. She can see to it that they reach competent medical help. It is with the hope that she will be assisted in this most important work at a time when all available hands are needed at essential war tasks that this paper has been written.

Many past therapeutic failures and most present ones are due to a lack of understanding of the basic factors respon-

sible for the disorder; or to a lack of knowledge concerning the proper methods that should be employed for their correction. Frequently, too much attention has been given to the role of contaminating organisms and too little to the disturbance of physiological function.

It has long been known that in persons with varicose veins, the venous pressure in the legs may be abnormally high when such persons stand erect. Numerous investigations have emphasized this point, outstanding among which is the excellent work of Warwick¹ who points out that incompetence of the venous valves is primarily responsible for the condition. This high venous pressure leads in time to edema of the lower leg which may cause the cells of the affected area to "sicken" and die spontaneously. Or it may allow them to be destroyed by a relatively minor injury. In this manner a varicose ulcer is formed.

ANATOMY

In the normal person the veins of the leg consist of two systems, a superficial and a deep one, which are joined by major and minor connections. The superficial system comprises the long and short saphenous veins and their tributaries. The deep system contains the femoral and popliteal veins and their tributaries. The two systems are separated by the deep layer of the deep fascia of the leg. (Figure 1).

There are two major connections between these two venous systems. They

VARICOSE ULCERS

are located in the groin and in the popliteal fossa, respectively. The first, or sapheno-femoral junction, is the one where the main long saphenous trunk empties into the femoral vein. The second or sapheno-popliteal junction is the point at which the short saphenous vein flows into the popliteal vein.

The minor connections, called perforator (or communicator) veins are variable in number and in location. A rather constant site for one or more of them is on the medial side of the lower half of the thigh as has been shown recently by Sherman.² Others are found on the medial, posterior and lateral aspects of the lower leg.¹

Normally the major vessels of the two venous systems possess check valves which are so arranged that the blood flows upward toward the heart and from the superficial to the deep system through the major and minor connections. (See arrows, Figure 1*). The valves usually occur just distal to the opening of a tributary and are located at frequent intervals along the course of the main venous stem.

The function of the venous valves is illustrated by a study of the sapheno-femoral junction (Figure 1) where three important valves are found. Two of them are located in the femoral vein, the first, or femoral valve is proximal and the second, or deep femoral valve (Warwick) is distal to the sapheno-femoral junction. The third is placed in the saphenous vein just distal to the complex of veins which enter it near the sapheno-femoral junction. When this principal valve of the saphenous vein fails to function properly (that is to say when it is incompetent) the blood which reaches the sapheno-femoral junction through the femoral vein tends to flow backward into the saphenous vein and partially obstruct the upward movement of blood in the latter vein. When the affected person stands erect this condition is exaggerated. If the valves in the saphenous vein below this point are also incompetent the obstruction pressure of the blood extends downward into the

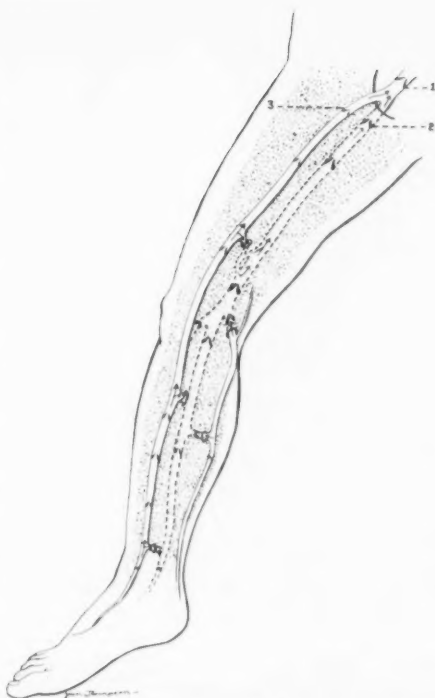


Figure 1
Diagram of Saphenous and Femoro-popliteal Venous Systems. (Shading indicates deep fascia).
1. Femoral valve. 2. Deep femoral valve. 3. Main saphenous valve.

leg and a stagnation is produced throughout the affected portion of the saphenous venous system. The stagnation is further accentuated by the re-entry of this delayed blood into the femoral system through the various perforator veins. Thus a circuitous flow of blood is produced which has been called a vicious cycle. It is important because of the depletion of oxygen and of the abnormal increase in waste products within the venous blood of the leg which it makes possible.

Quite frequently Valve 1 is incompetent also. When this occurs a strain is put upon the long saphenous vein by anything that increases intra-abdominal pressure, such as coughing, straining, child bearing, et cetera. Under these conditions the in-

*A notable exception to this pattern occurs in the foot where the flow is from the deep to the superficial veins.

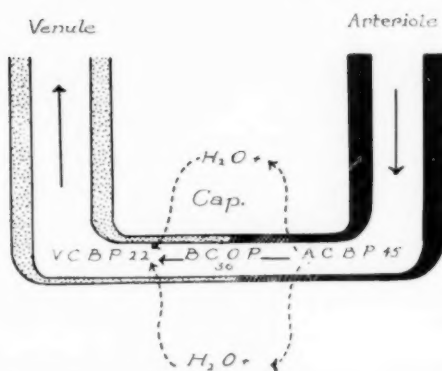


Figure 2
Diagram of Capillary. Figures refer to pressure in cm of water. Cap. = Capillary. V.C.B.P. = Venous capillary blood pressure. B.C.O.P. = Blood colloid osmotic pressure. A.C.B.P. = Arterial capillary blood pressure. H_2O = Water plus dissolved substances.

tra-abdominal tension presses upon the blood in the inferior vena cava, and through it exerts an additional downward pressure into the leg veins. It is quite likely that the absence or ineffectiveness of Valve 1 may be the first stage in the development of saphenous system incompetence in a considerable number of persons.

PHYSIOLOGY

The high venous pressure which these defects produce is maximal in the lower part of the lower leg where it exerts a deleterious effect upon capillary function. The manner in which this function becomes distorted is evident from a study of the normal intra-capillary pressures. The excellent work of Landis and his associates is apropos. In 1934 Landis³ summarized their observations and reported that the average pressures in man were as follows: (a) arterial capillary pressure 45 cm of water (b) blood colloid osmotic pressure about 36 cm of water and (c) venous capillary pressure about 22 cm of water. The significance of these observations is clear when it is recalled that the blood capillary in the course of its function as a distributing system, acts as a semipermeable membrane. That is to say, it allows water and certain dissolved substances to pass freely while retaining the

blood colloids. Since the latter have the power of drawing water through such a membrane, a power that is expressed as the colloid osmotic pressure, a superior force is necessary to move water out of the capillaries. This force is present in the arterial capillary and is equal to the difference between the arterial capillary pressure and the blood colloid osmotic pressure (about 9 cm of water on the average). The opposite influence is present on the venous side of the capillary where the colloid osmotic pressure is distinctly higher than the venous capillary pressure (about 14 cm of water on the average). It insures the return of water into the blood vascular system and completes the normal cycle of the circulation of fluid in the tissue spaces. (Figure 2). Any condition which increases the venous pressure tends to lessen the effectiveness of the drawing power of the blood colloids and to prevent water from re-entering the blood vascular system. When the volume of water that remains in the tissue spaces is marked it becomes evident as edema. When the edema is uncontrolled, injury to the lower leg or disturbances in the cells of the affected area, due to lack of normal tissue fluid circulation, will often lead to a break in the skin which heals very slowly. It is in this manner that incompetence of the venous valvular system leads to ulcer formation.

ETIOLOGY OF VALVULAR INCOMPETENCE

Disabling incompetence or ineffectiveness of the venous valves may occur as the result of one or more of the following causes.

1. Defective development of the valve itself.
2. Excessive dilatation of the vein at the site of the valve.
3. Subjection of a normal or slightly defective valve to serious injury by a sudden rise in intra-abdominal pressure.
4. Destruction of a normally developed valve by thrombophlebitis.

1. Defective Valvular Development

Normally a venous valve consists of two, tissue-paper-thin, cupshaped sacs,

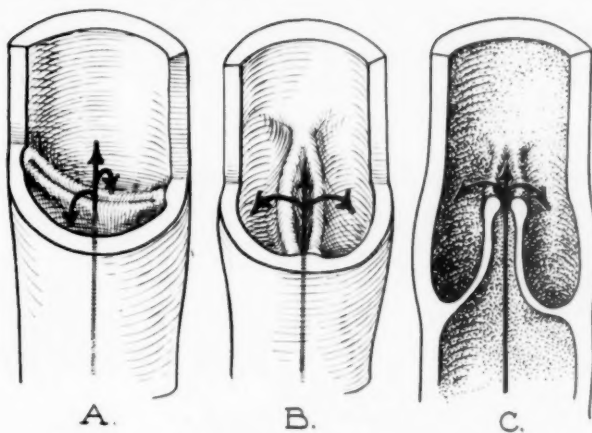


Figure 3.
Diagram of normal venous valve.

attached to opposite sides of the vein wall with the open face directed toward the heart. (Figure 3). When the vein above them is filled with blood the edges of the sacs meet in the middle of the vein and close the opening, thereby preventing the downward movement of blood. However, they give way easily to pressure from below and allow blood to move upward whenever the pressure is increased sufficiently. One or both of the sacs may be defective in form or may be absent. In young, active persons with good tissue turgor this defect may not be evident at first. Soon, however, the high intravenous pressure expresses itself through the appearance of veins that are more than normally prominent. As these persons grow older and less active the venous pressure gradually causes an increase in the size of the veins and a thinning of the vein walls. This process may create, by dilatation alone, an incompetence of certain of the secondary valves in the saphenous system. Thus it spreads slowly to involve a progressively larger part of the venous bed. In cases with marked congenital defects, full blown varicosis may appear in the late "teen" age or early twenties. Defective valvular formations of this type may be due to chance errors in development. In other persons it often seems related to a hereditary tendency.

2. Abnormal venous dilatation

Sometimes the walls of a vein are ab-

normally thin due to a weakness in development, and give way to pressure easily, permitting enlargement of the vessel lumen. At other times one sees an apparently normal venous system in the female enlarge during pregnancy presumably as the result of some chemical stimulation associated with sex activity. In either case, the dilatation may occur at the level of a competent valve and render it incompetent.

3. Destruction of valves by injury

Occasionally varicosis appears gradually after an incident involving the sudden, sharp rise in intra-abdominal tension. The sequence of events suggests that the sudden application of force to the blood in the inferior vena cava injured the femoral or main saphenous valve and rendered it incompetent. Whether such an injury can destroy a normal valve or only one in which there is a potential weakness cannot be stated. This type of disorder appears to be quite rare, however.

4. Destruction of valves by thrombophlebitis

The causes of valvular incompetence described above are usually apparent only in the femoral or main saphenous valves (No. 1 and 3). On the other hand, thrombophlebitis commonly occurs in the femoral or iliac veins where it involves and destroys the effectiveness of part or most

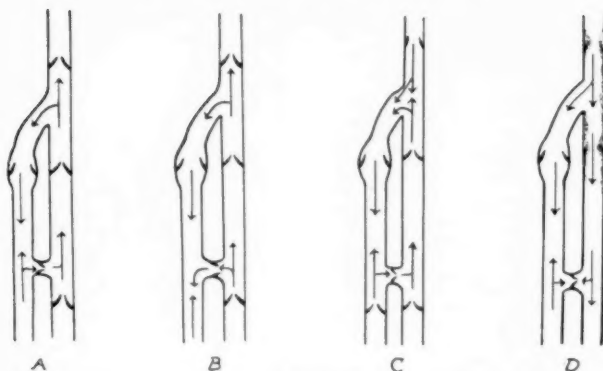


Figure 4
Diagram of Forms of Venous Incompetence. A. Incompetence of main saphenous valve. B. Incompetence of main saphenous and thigh perforator valves. C. Incompetence of femoral-main saphenous valves. D. Recanalized thrombophlebitis producing incompetence of femoral and deep femoral valves and associated with incompetence of main long saphenous valve.

of the femoral valvular system. When this occurs the clot becomes attached to the vein wall in the region of the valve and incorporates the delicate leaves of the latter in a heavy, contracting mass. Then, as the clot organizes and the lumen of the vein is re-established through the process of recanalization, the valve is distorted or completely destroyed. When the process is mild, the incompetence is often slight. When it is severe the saphenous vein will be called upon to compensate for the femoral block by carrying amounts of blood in excess of its normal capacity. In the course of such a response, enlargement of the saphenous vein and the development of incompetence of its valves is a usual phenomenon. Then as the femoral thrombosis recanalizes, the enlargement of the saphenous vein becomes a venous liability which can only be corrected by elimination.

The various features of valvular incompetence are shown diagrammatically in Figure 4.

SYMPTOMS

Incompetence of the saphenous vein followed by formation of a varicose ulcer usually is associated with a certain sequence of events. At first visible veins appear in the thigh or lower leg. These spread gradually. Then, after a variable period of years the patient notices a

heaviness and swelling in the legs which occur during the daily period of activity and subside during the period of rest. The swelling and discomfort are ordinarily more evident when the patient has to stand still than when he is moving around actively. Occasionally the discomfort is noticed along the course of the saphenous vein in the thigh. It is frequently aggravated during the menstrual period. Then, when the patient retires an uncomfortable aching may occur in the affected leg and last for an hour or more. When the edema has persisted for some time, reddish or brownish discoloration of a portion of the lower leg appears and is often associated with an induration or hardening which is usually located on the medial side of the lower part of the lower leg and involves the skin and subcutaneous tissue. Finally, a break in the continuity of the skin occurs spontaneously or as the result of a bruise or more severe injury and fails to heal. An ulcer is thus formed. Such ulcers are seen most often on the medial side of the leg proximal to the malleolus. Occasionally they appear over or distal to the malleolus.

When an ulcer occurs as the result of incompetence of the femoral valvular system arising from thrombophlebitis of the femoral or iliac vein a somewhat different story is elicited. First there is the history of the occurrence of an attack of

VARICOSE ULCERS

"milk leg" following child birth, an operation or a profound illness, in which swelling of the entire limb occurred quite abruptly and was associated with varying degrees of chills, fever and leucocytosis. When the process is mild the initial symptoms disappear, visible varices are often absent and the patient may go for years without trouble. However, in some persons this mild attack is followed some years later by swelling, induration, and ulcer formation without the presence of prominent superficial veins.

When the thrombophlebitis has been severe, enlargement of the saphenous vein is the rule and is associated with varying degrees of involvement of the saphenous and perforator valvular systems. At first this enlargement is beneficial, as it compensates for the loss of function in the femoral vein. But when the thrombus in the latter vein recanalizes the condition of the saphenous vein becomes a liability, due to the vicious cycle which is set up between the two systems as described earlier in this article. Then edema, induration and finally an ulcer develops. The time when the ulcer appears following the attack of thrombophlebitis is quite variable ranging between a few years to 10 or more. This type of ulcer is occasionally seen to occur on the lateral side of the ankle.

A disturbing characteristic of varicose ulcer is the severe pain with which it is associated. It may be so marked that the patient is incapacitated. The degree of pain is not always proportional to the size of the lesion. Small ulcers about the distal part of the ankle are some times more painful than larger ones located at a higher level.

TREATMENT

The successful treatment of varicose ulcer is divided into two parts. First the ulcer must be healed and second the processes which are responsible for its formation must be corrected or brought under control.

Rapid healing of the ulcer will occur under any condition that counteracts the

influence of the high venous pressure. If the patient is put to bed with the affected leg elevated the most perfect correction is established. Unfortunately, this method has many undesirable side effects. It keeps the patient from gainful employment or from fulfilling the responsibilities of daily living for considerable periods of time. Moreover, it places a burden on the family financially and otherwise, which often cannot be met successfully, particularly when the patient is the breadwinner or a mother upon whom the care of the home is dependent. These persons need a form of treatment which will restore their ability to work or keep them at their job when discomfort threatens to prevent normal activity.

A number of procedures have been used for this purpose. "Ace" bandages are useful as a temporary expedient, but are not especially effective since they tend to slide and fit poorly. When used, they should be put on before the patient arises and must be kept on during the entire daily period of activity. The ulcer is of course covered with gauze dressings.

Unna's Paste Boot is a better support for the material stays more firmly in place. However, the paste and gauze cannot be put on tightly. Therefore, if edema is present at the time of application it will remain in the leg. Moreover, in warm weather the gelatin will tend to soften and stretch. When more perfect methods are not available, this one should be used. The wall should be made thick enough to hold firmly and smooth enough to avoid cutting into the leg. Only the toes, metatarso-phalangeal joints and the very tip of the heel should be left uncovered.

Elastoplast or similar elastic adhesive bandage has become quite popular in some sections of the country. It is very effective when properly used, but is more expensive than ordinary adhesive tape and may cause skin irritation in susceptible persons.

McPheeters,⁴ using an adaptation of Brodie's⁵ adhesive method, plus a rubber sponge as advocated by Nobl⁶ has popu-

larized a very effective ambulant treatment. Our modification of this method has been described elsewhere.⁷ Briefly, the skin is cleansed and then "painted" from the metatarso-phalangeal joints to the level of the tibial tubercle with a 10 or 15 percent aqueous or alcoholic silver nitrate solution which is used to combat tinea infection. Occasionally it will cause the skin to blister from irritation and must be discontinued. The ulcer surface and skin for a short distance beyond the ulcer is then covered with adhesive tape to protect the epithelial edges. The "painted" area is now enveloped in a sheet of cotton which is held in place by gauze bandage. The achilles tendon is padded well. Then a one-half inch sheet of foam rubber, cut to cover the ulcer and the surrounding indurated area, is wrapped in place by gauze bandage and the entire area is incased in adhesive tape. Wherever edema is present the tape is applied with great firmness, squeezing the foam rubber sheet tightly against the leg.

After the first application the patient may be very uncomfortable, but as the edema disappears and the ulcer begins to heal, the support is greatly enjoyed. Occasionally the patient may have to remain off his feet for a day or two. In general, however, he should be encouraged to return to activity as early as possible. During the first two to three weeks of treatment the support should be changed every four to seven days in order to reduce the discomfort caused by wetting from the ulcer surface and in order to "take up the slack" as the edema subsides. Later a single support can be worn for ten days to two weeks. When the ulcer is healed and this type of support is required for economic or other reasons, before final corrective measures can be employed, patients may tolerate a single dressing for a month or longer.

It has been our experience that an average-sized ulcer can be healed by this method in from four to six weeks during which time only a few days will have been lost from work or other duties.

If the patient has the type of post-thrombophlebitic incompetence which occurs without enlargement of the veins of the saphenous system, a heavy, made-to-measure, elastic stocking must be fitted to the leg when the ulcer is healed. It must be worn during the daily periods of activity as long as the leg shows any tendency to swell. This may be for the rest of the patient's life.

When the ulcer has been healed for two weeks or longer and when the skin appears to be good and firm, the second phase of treatment is instituted. This consists of destruction of the incompetent saphenous veins. The procedure is the same for saphenous vein incompetence following femoral thrombophlebitis as for uncomplicated incompetence of the saphenous system, providing the femoral veins have been found to be recanalized by appropriate tests (von Perthe). The procedures employed have been the subject of constant study and variation.

In the early part of this century ligation and stripping of the saphenous vein were tested extensively. However, as they were then employed, the disabling effects on the patient and the frequency of complications were such that other more conservative methods were sought. For a time, the injection of sclerosing solutions was used exclusively in many clinics, but was found to be incomplete because of the reopening of the vein through recanalization of the clot often in from six months to two years. Then Moszkowicz⁸ developed the combined ligation and injection treatment on ambulatory patients which was popularized in this country by deTakats.⁹ Recently, Sherman² pointed out some reasons for failure of this procedure as it is usually employed, and demonstrated in this connection an important constancy of the relation of the thigh veins to their perforator branches, which seems to have been overlooked by earlier workers. He described an operation based upon these observations which combines injections, ligation, and stripping in a manner which gives promise of yielding very excellent and permanent results. We

VARICOSE ULCERS

have had the privilege of testing this method during the past two and one-half years and have found it very effective.

We have considered in detail several features of the problem of varicose ulcer in the belief that a thorough understanding of the principles involved as well as of the practices employed is the best preparation the public health nurse can have to meet her responsibility. The degree in which she will be required to use this knowledge will depend, in part, on the alertness of the consulting medical service.

Neglected varicose veins and varicose ulcer are a common occurrence in persons who come under the supervision of the public health nurse. This is due to many causes, chief among which is probably limited financial resources. However, these persons often continue to suffer inconvenience and disability because they have become discouraged by the failure of previously employed therapy and do not know where to get adequate attention. Occasionally they will be found to be patronizing services that are not able to give proper care. In addition to assisting her patient in this manner, the well-informed public health nurse can do much to help others prevent the development of varicose ulcer by directing those who are

suffering from varicosis and who have an associated edema and induration to sources of proper medical attention before an ulcer forms. For this purpose she may require the maximum utilization of tact and that gentle urging that is so large a part of her psychological armament.

In larger communities, clinics will be available for such services with which she can cooperate closely. In smaller communities she may be able to work with the local medical profession in setting up the proper curative services when they are not present, or in arranging with them to have the patient sent to a larger center.

She will also be alert to the value of instructing patients, who are suffering or have suffered from thrombophlebitis, in the care they must give to the affected leg so as to prevent the development of symptoms, or worse, the formation of varicose ulcer. She may even be called upon to help the patient overcome a prejudice against the wearing of elastic stocking supports.

Finally it will occasionally be her unhappy duty to assist her patients in the obtaining of incomplete, but reasonably adequate, treatment because of a lack of financial or professional resources that will not permit the utilization of the most favorable form of therapy.

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Breakdown in Early Tuberculosis

By SAMUEL C. STEIN, M.D.

Many danger points bar the road to recovery of the patient with early tuberculosis warns the author. Early diagnosis is only a first step along the way

WITH THE increasing opportunity to find early or minimal pulmonary tuberculosis on a large scale, by the draft and through industrial and other surveys, it is important that we become cognizant of existing problems pertaining to minimal pulmonary tuberculosis.

The prevalent opinion that the finding of active tuberculosis in a minimal stage warrants an excellent prognosis is true only if qualified by the statement—"if adequate treatment is taken." Many reports published, particularly those indicating very good results, have been submitted from sanatoria. It must be recognized that the sanatoria outlook upon minimal pulmonary tuberculosis is not the same as that in the diagnostic clinics when the early diagnosis is first made.

The difference of opinion may be attributed to certain circumstances. The number of minimal pulmonary tuberculous cases in sanatoria has not increased in direct proportion to the number of cases found. The failure to see and follow many diagnosed cases explains the sanatoria impression. There are individuals who reach the sanatorium with minimal pulmonary tuberculosis whose disease shows no progression even though weeks or months elapsed between the time of diagnosis and admission to the sanatorium

for treatment. These are the more resistant cases. On the other hand, among patients found in surveys and particularly among those in contact with sputum-positive tuberculosis, there will be found a significant number with low resistance whose disease will progress rapidly before sanatorium care is finally sought and obtained.

In the Henry Phipps clinic, even though the serious potentialities of minimal pulmonary tuberculosis are recognized and the physicians and nurses endeavor earnestly and persistently to overcome obstacles that prevent adequate care of these patients, our results are astonishingly poor. A study of minimal tuberculous cases presented to our conferences has shown that almost 50 percent developed progressive disease. This was true of both white and colored patients. The same study revealed mortality figures of 25 percent for the colored patients and 6 percent for the white. A review of those cases that died showed that only one had obtained sanatorium care, and then when she had already progressed to an advanced state.

The "early discovery" of pulmonary tuberculosis, by which is meant discovery of the disease in a minimal stage, is almost useless unless it can be followed by adequate treatment.

BREAKDOWN IN EARLY TUBERCULOSIS

WE must seek the causes of our poor results and remedy them if we are to make important strides in the control of tuberculosis through the discovery of minimal disease. It is after the diagnosis is made that we encounter the most serious obstacles. The following factors are the dominant ones and although all will not be applicable to every locale, the majority probably will.

The first problem to be considered is the diagnosis of minimal pulmonary tuberculosis. It is universally accepted that the X-ray is the most proficient method. The perception of a minimal tuberculous lesion in an X-ray film usually presents no problem. Determination of the status of the lesion is anything but simple. Minimal tuberculosis may fall into one of three categories: (1) lesions whose appearance indicates active, unstable disease (2) lesions whose appearance indicates disease of doubtful significance and (3) lesions whose X-ray appearance suggests that the tuberculous process has undergone complete healing and that the disease has no apparent clinical significance.

It must be remembered that there is no specific laboratory test for determining the activity of a lesion and that the X-ray interpretation is a subjective one even though the film itself be objective. Hence, we come to the first crossroad in the problem of minimal pulmonary tuberculosis, that is, the determination of the character of the lesion which will in turn influence our recommendations for treatment. The determination of the character of the lesion is based largely upon experience with similar lesions that have been observed for long periods.

Many phthisiologists advocate the follow-up of contact cases for a period of two years after known exposure ceases. Certainly it is just as important to follow for a similar period those cases that have

definite lesions but fall into the second and third categories of significance, to insure their diagnosis of stability.

As previously noted at the Institute, almost 50 percent of patients showed progression of disease and of these 86 percent developed extension of disease within the first year, the remainder within a period of three years. Although serial X-ray film examination does not prevent progression of a tuberculous lesion, it enables us to determine at the earliest time those cases in which the status of the lesion has not been accurately estimated.

ONCE the diagnosis is arrived at a very grave problem must immediately find solution. This is the rapport between the physician, nurse, and patient. It is at this point that the psychological reactions of the patient to his disease and its treatment will be influenced by his confidence in the doctor and nurse. In most instances the lesions are almost asymptomatic if not entirely so. It is a difficult matter to convince a patient to take such "drastic" treatment as absolute bed rest when he is, according to his own standards, not "ill."

The patient found by survey methods is one who did not seek the advice of the investigator. When informed of the presence of disease he scoffs at the diagnosis and only too frequently refuses to believe that he has a serious ailment.

Again, patients are invited to the clinic for examination because of contact with known sputum-positive patients. Many avail themselves of this opportunity for a medical examination but only because they wish to be told that there is nothing wrong with them. When confronted with a positive diagnosis they become antagonistic and refuse to accept advice.

Should these difficulties be surmounted, the economic situation arises. If the patient is the provider or caretaker of a

PUBLIC HEALTH NURSING

family, he or she is naturally loathe to leave behind a situation of destitution for the ones he loves by accepting treatment which must necessarily be a prolonged hospitalization. Society has done little to overcome this exigency. Since even the argument that he is endangering his family will not bear weight with a patient who does not feel ill, it is essential to remove the economic problem if we are to gain and keep the cooperation of the patient.

FROM this discussion, one begins to appreciate some of the problems that arise between physician, nurse, and patient. Assuming then that deterrents to treatment such as these are removed, the clinic physician and nurse find they must now overcome the problem arising in hospitalization itself. In some communities hospitalization may be readily obtained but adequate care is almost impossible because of the increasing depletion of personnel. This leads to the use of patients who look well externally as patient-employees. The patients are liable to decide that if they can work in institutions they might just as well return home to their previously gainful employment.

Many institutions require positive sputa before admitting patients. This obviously results in progression of disease

before the patient gains the needed bed.

This tendency in many institutions to give patients with minimal tuberculosis short periods of rest because of the notion that a little tuberculosis requires only a little treatment is inexcusable, and leads to the frequent later relapse of the lesion.

Again many sanatoria presumably because of restricted funds, depend chiefly upon clinical phenomena to determine the stability of a lesion. This is the practice of tuberculosis as it was 20 years ago. When applied to minimal asymptomatic pulmonary tuberculosis it defeats the purpose of surveys since patients originally found without clinical manifestations will not receive treatment.

Thus, in many instances, lack of treatment or too early discharge of the patient results in the necessity for return to a sanatorium or hospital at a later date, usually with progressive disease.

This is a review of the chief obstacles in the management of early tuberculosis. Each one considered as a faulty cog in a machine tends, if allowed, to prevent the production of a final unit, namely, the return of an individual to a productive state in his community.

Delivered at Tuberculosis Institute, sponsored by The Henry Phipps Institute for the Study, Treatment, and Prevention of Tuberculosis, The University of Pennsylvania, Philadelphia, Pa., May 5, 1942.

Public Health Nursing in the Industrial Hygiene Program

By MARY D. FORBES, R.N.

NURSING IN industry in the United States had its beginning nearly half a century ago, when the first nurse was employed by the Vermont Marble Company in 1895 to give nursing care to sick employees and their families. As the scope of the industrial hygiene program has expanded and developed, so also has the emphasis of the nursing program been changed until today many different replies are received to the question, "What is industrial nursing?" One definition, which represents the trend toward the recognition of the broad public health aspects of nursing in the modern industrial hygiene program, states, "Good industrial nursing means the full care of the patient in all its preventive, curative, economic, and social aspects."¹

Another explanation of industrial nursing is given by the president and general manager of a large paper mill corporation, in which he points out what nursing does for the employer and the employee. Joseph M. Conway says of industrial nursing:

"It is a builder of goodwill.

"It makes a satisfied worker.

"It increases the efficiency of workers.

"It reduces the cost of production."²

Never has there been a time in our history when the need for the type of service implied by these definitions was so great as it is today. With approximately one third of the total population of the United States (1940 census enumerated

52,000,000 workers) employed in some sort of industry, with an ever-increasing number of women leaving their homes for work in essential war industries, the industrial hygiene program has come to be one of the most deserving of well-directed effort. It can no longer be considered the responsibility of industry alone to provide for the health and welfare of this army of workers. The great expansion in war industries has brought about many health problems relating to housing, medical care, and health protection for the workers and their families, for which the community must share responsibility.

Dr. Thomas Parran has pointed out that industrial hygiene must increasingly gear in with the other health services in our local areas. Just as nursing now is regarded as an essential part of any good public health program, so ever-increasing recognition is being given to the important role which nursing plays in the industrial hygiene program.

Until recently, little has been known of the amount and kind of nursing services that are available in industries throughout the country. However, studies have shown that there are serious inadequacies in medical and nursing services for industrial workers, particularly for those employed in small establishments.

A nationwide study of approximately 17,000 establishments employing more than a million and a half workers made by the United States Public Health Service (1936-1939), showed that only one third

of the employees had the services of a full-time nurse. Part-time nursing services were available to less than two percent of all the workers in the industries studied.³

A survey of 900 industrial plants in California, made by the State Department of Health about two years ago, showed that only 40 percent of the workers were provided with any form of nursing services. The services of a full-time registered nurse were available to 29 percent of the workers; services of a part-time registered nurse were available to 1.5 percent; the services of a full-time nurse with public health training were available only to approximately 3 percent of the employees.⁴

These and other studies showed that most of the nurses are employed in large manufacturing establishments. Yet about two thirds of the industrial population is employed in smaller plants, which comprise over 90 percent of the industrial establishments in the United States.³

The problem of providing more adequate nursing services for workers in the smaller industries is, then, one of the most important that we have to face today when our public health programs are being adjusted to meet the war needs.

Probably no branch of nursing has undergone greater developments during the past year than has industrial nursing. Let us consider a few of the progressive steps which have been taken.

INCREASED AMOUNT OF NURSING SERVICE

The first essential in providing adequate health services is, of course, that of providing a sufficient number of qualified physicians and nurses.

The count of public health nurses, made each year by the United States Public Health Service through the various state departments of health, shows a considerable increase in the number of nurses employed by industrial establishments. On January 1, 1937, there were 2,203

graduate nurses reported as being employed for full-time service in industries throughout the United States. In 1941 the National Survey of Registered Nurses showed 5,512 industrial nurses. Similar information for 1942 is not yet available for the entire country. All of the industrial nurses included in the 1937 count were employed for full-time service; therefore, most of them were in the large industrial establishments.

We may well ask, then, "What is being done to provide more adequate nursing services for the smaller industries?"

The Committee on Healthful Working Conditions of the National Association of Manufacturers has been studying the possibility of small plants purchasing part-time nursing service from local nonofficial public health nursing agencies.

A committee of the American Public Health Association for the development of industrial hygiene in local areas held a special meeting during a recent convention, at which time consideration was given to the development of part-time medical services in small industries. As a result of this meeting, suggestive plans were outlined for the development of part-time services in communities where nonofficial public health nursing associations are already established. According to these plans, the responsibility for promoting such services should be assumed by the state divisions of industrial hygiene, since these divisions are aware of the needs of industry and are also in a position to make recommendations for measures to protect the health of the workers. Without this assistance, it has been found difficult for the nonofficial agencies to estimate the needs of industries, and for the industries to be convinced of the value and the availability of the part-time service, which might be provided.

Approximately 17 nonofficial nursing

agencies are known to have contracts for part-time nursing service in 31 industries.⁷

One of the most successful part-time public health nursing services is that provided through The Visiting Nurse Society of Philadelphia. The details of the plan, whereby part-time public health nursing services were provided in five industrial plants in Philadelphia over a period of eight years, are known to many of you. They are described in an article in the January 1941 issue of *PUBLIC HEALTH NURSING*.⁵

NURSE CONSULTANTS IN INDUSTRY

Another encouraging trend is the recognition, in an increasing number of states, of the responsibility which state health departments have for promoting adequate nursing service for the ever-growing number of industrial workers and their families.

Fourteen of the 48 state health departments have appointed public health nursing consultants for industrial hygiene services. All but one of these consultants have been assigned during the past two years. These states are: California, Connecticut, Georgia, Illinois, Indiana, Mississippi, Michigan, Missouri, New Jersey, North Carolina, Ohio, South Carolina, Tennessee, Wisconsin.

The plans of these various states indicate considerable uniformity in the functions which have been outlined for the consultants. These functions have been summarized under the following headings:

1. To give assistance to the medical and engineering personnel of the division of industrial hygiene in developing a statewide industrial hygiene program
2. To give consultation service to industries not yet employing nurses
3. To give consultation service to industrial nurses
4. To promote an understanding of, and an interest in, industrial nursing within the professional nursing groups

5. To provide in-service education in industrial hygiene for the nursing staff of the state health department

6. To plan for and promote the coordination of all community nursing services for the benefit of industrial workers⁶

Considerable impetus has also been given to the development of industrial nursing through the recent appointments of public health nursing consultants for industrial hygiene by the United States Public Health Service, and by the National Organization for Public Health Nursing.

STUDY OF DUTIES OF NURSES IN INDUSTRY

In the past, little information has been available concerning the range of activities included in the field of industrial nursing. In order that intelligent assistance may be given by nursing consultants and others in the development of more adequate nursing services to industrial workers, it is necessary to have authentic information relating to problems and actual practices of nurses now employed.

In 1940, the Committee to Study the Duties of Nurses in Industry under the chairmanship of the public health nursing consultant for industrial hygiene of the United States Public Health Service was established by the Public Health Nursing Section of the American Public Health Association. The purpose of this study as outlined by the Committee was to provide:

1. An aid in the recruitment of nurses for the specialized field
2. A guide for nurses about to be employed in industry for the first time
3. An aid to the nurse already employed seeking to improve her professional knowledge and skill
4. A source of information for employers considering the establishment of a nursing service
5. A guide to schools of nursing and

PUBLIC HEALTH NURSING

universities offering public health courses

Under direction of this committee, data were collected by the consultant nurses in the various state departments of health, and will be tabulated and analysed by the Division of Industrial Hygiene of the United States Public Health Service. From the information thus obtained, a committee composed of representatives from the organized industrial nursing groups will prepare recommendations relating to standards for nursing practice, desirable qualifications for nurses in industry, and other factors which industrial nurses consider essential for the development of nursing in the industrial hygiene program.

The chief function, and in many instances the only function, of nurses in industries has been the treatment of traumatic injuries. Today, with the growing acceptance of a public health point of view by physicians, nurses, employers and employees, the scope of the industrial hygiene program has been expanded to include, in addition to the treatment of traumatic injuries: the prevention of occupational and nonoccupational diseases and injuries, and the promotion of robust health.

This broadening of the scope of activities demands of the modern industrial hygiene program increased emphasis upon educational and preventive measures. Therefore nurses are realizing more and

more the necessity for special professional preparation. Today nearly all of the universities which offer approved curricula in public health nursing include courses in industrial hygiene. Several universities have planned more extensive programs of study which combine academic work and observation, or actual experience in industrial establishments.

In summary, I should like again to emphasize some of the "unfinished business" that challenges nurses in relation to industrial hygiene.

1. Although the number of nurses employed for full-time service in industry has been increased considerably during the past two years, the great majority of workers are still without adequate medical and nursing service.

2. Increasing efforts must be made in critical industrial areas to provide part-time nursing services through existing agencies to small industries and to sick employees and their families in their homes or barracks.

3. The ever-expanding scope of activities in the field of industrial hygiene with greater emphasis on prevention and education brings with it the need for better prepared nurses who are equipped to develop the broad health aspects of the program.

Presented at the Western Branch meeting of the American Public Health Association, Seattle, Washington, May 28, 1942.

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Educational Qualifications of Public Health Nurses

A SERIES of studies throughout the past year have reviewed the facts revealed in the First National Survey of Registered Nurses, January 1, 1941.* The latest of these** discusses the educational qualifications of the 300,000 nurses in public health nursing, institutional, private duty, and other nursing work who returned questionnaires. Certain facts relative to the academic education of 24,000 public health nurses are here briefly noted. Of the 24,000 nurses, 17,619 were actively employed at the time of the survey; 6,614 were inactive.

On the whole the actively employed public health nurses showed somewhat better academic training than institutional, private duty, and other nurses. Thirteen percent had college degrees, 56 percent some college work without degrees. Nine percent had not completed high school. It is pointed out that a Grading Committee study in 1928 showed that only 20 percent had completed some college work as against 69 percent in the 1941 survey. Inactive public health nurses reported less in the way of academic preparation than those actively employed: only seven percent had college degrees, 43 percent had had some college work, while 15 percent appeared not to have completed high school.

When the figures are studied relative to age—public health nurses under 40 and those 40 and over—it is seen that the

younger group included a larger number with college preparation than did the older. The reason for this probably is that public health agencies usually require some advanced educational preparation of general staff nurses. This has been especially true as to young nurses entering the public health field. The older experienced nurse already employed is more apt to be exempt from this requirement.

The "sphere of responsibility" of those reporting has been divided into: (1) nurses listing their functions under administration, supervision, and teaching and (2) all others as "general staff." In public health nursing 21 percent of "administrators" and 9 percent of staff nurses were college graduates. Fifty-nine percent of the first group, 54 percent of the second had some college preparation.

The younger group in administrative positions showed about the same college attainments as did the older group, about 21 percent being college graduates. Of public health staff nurses, 11 percent of those under 40 had college degrees, compared to only 5 percent of those forty and over.

In conclusion, the author states in relation to all nursing education, "Its progress has been steadily and consistently in the direction of more 'adequate preparation.' However, from the figures presented it is also evident that although nursing can point with pride to its past performance, it must diligently and forever bear in mind that this past has but paved the way for future accomplishment. The national picture of nursing education in 1941 would truly justify the nurse of today in saying to the nurse of tomorrow:

'Whereof what's past is prologue,
what to come

'In yours and my discharge.'"

*PUBLIC HEALTH NURSING, January 1942; *American Journal of Nursing*, January and July 1942.

**"What's Past Is Prologue" by Henrietta Landau, associate public health nursing consultant, U. S. Public Health Service, will be published in full in a forthcoming issue of *Public Health Reports*. A summary appears in the March 1943 issue of the *American Journal of Nursing*.

Our Puerto Rican Patients

By ANN CATON, R.N.

WE CANNOT speak of Puerto Ricans as acting according to set patterns any more than we can say that Americans or Italians or Irishmen do. Puerto Ricans have different strata in their social and economic life, they differ as individuals.

I know little about them as a whole. My work has been largely confined to those in the lowest economic level. But, I have sensed so much antagonism toward the Puerto Rican that I feel we, as public health nurses, should analyse this attitude, see what in the background of the poor Puerto Rican makes him live as he does, if we are to contribute to his health and happiness.

When I fell heir to a 70 percent Puerto Rican district some eight or nine years ago, I was given to understand that Puerto Ricans were dirty, immoral, unteachable, certainly anything but lovable. I was not expected to do much with them. This same feeling was reflected in the clinic which my Puerto Rican families attended. "Oh, Puerto Rican," if I inquired for a special patient, "it doesn't matter whether they come to clinic or not—they never do what you tell them." And from social agencies, "Can't do anything with them," "Never know how many in the family," "They don't even know their own names."

My district was to me what a defective child is to an adoring mother. Of course, I had to admit that some of the homes were dirty according to our standards, their moral code was different, they accepted nursing care with reluctance. But

I found them unfailingly polite and surprisingly teachable even while apparently paying only the most casual attention to the matter at hand. More than one mother has invited me to sit down and continued her lace-cutting or household tasks, hardly seeming to recognize my presence. Yet the next visit would find evidence of learning—some suggested food in use or a baby's bath perfectly performed. They accepted me but did not seem to care whether I came or went.

One day after several weeks' absence, I visited a mother with a young child. After a little polite conversation about the family, there was a silence. In a few minutes the young mother said very quietly, "I am glad you are here, I have a missing for you." As a nurse I had been endured but as a friend I was sincerely missed. Puerto Ricans were no longer a disliked group to defend but friends to understand and love.

IN understanding the Puerto Rican, books written by the Spanish or Americans are not too helpful. It is in their homes that we learn to understand them best. However, historical records do contribute to our knowledge of the Puerto Rican background, and give us basis for a better appreciation of their characteristic reactions and feelings.

The original Puerto Ricans, as found by the Spanish Conquistadores about 450 years ago, were probably Carib Indians known as Borinquens. They were copper-colored with long, straight, black hair, somewhat darker in color and smaller in

PUERTO RICAN PATIENTS

stature than our North American Indians. They were a peaceful, friendly people, carrying on a simple agricultural life. They were easily conquered by the Conquistadores, a group largely made up of adventurers, thieves, and convicts, who quickly enslaved most of the population. Those who fled to the hills soon died out, and as a pure race the Borinquens were practically extinct in about a hundred years.

From this combination of Spaniard and Borinquen began to develop the Puerto Rican, in whom the physical characteristics of the Carib Indian still persist. Negro slaves were brought into Puerto Rico about the same time they were introduced in the United States. Slave owners for the most part lived in the coastal cities, so the Puerto Rican coast has a Negro population. There is also a Portuguese strain introduced by a company of Portuguese soldiers that was sent to garrison the Fort in the sixteenth century. Out of this mixture has evolved the Puerto Rican of our time. He is classed as white unless he is obviously and predominantly Negro. The race separation is not distinct; there may be colored and white Puerto Ricans in the same family. It is generally agreed that the "jibaros," the large rural group that forms the biggest percent of the total population, is essentially a combination of Spaniard and Carib Indian. The "jibaros" are classed as white. However, the largest number of Puerto Ricans coming to New York are from the coastal cities.

After the 400 years of Spanish exploitation the United States took over the island of Puerto Rico in 1898. They found a rugged little island about the size of Connecticut with a population of a million people—poor, ignorant, hungry—but proud and independent. There was not one single public school in Puerto Rico. Eighty percent of the population was

illiterate. Trial by jury was unknown. Health conditions were deplorable. In addition to bad government, Puerto Rico suffered from tragedies of nature as well. In 1899 the island was swept by a disastrous hurricane. In 1918 part of the island was destroyed by an earthquake and a tidal wave, followed by an influenza epidemic. All took huge tolls in a debilitated and bereaved population. In 1928 the island was again swept by a destructive hurricane.

DURING the 44 years of United States rule this country has done a great deal to provide educational, housing, and health facilities to the people of the island. But the health situation though much improved makes a poor showing compared with the United States. In 1931, a period when many Puerto Ricans were coming to the States, the general mortality rate was twice that of the United States. The general infant death rate was three times as great, deaths from diarrhea and enteritis 15 times. The tuberculosis death rate was three times as high. Naturally these high mortality rates are reflected in the high mortality and morbidity rates among Puerto Ricans in the States. The average length of Puerto Rican life is said to be 45 years. I have never known but one chronologically-old Puerto Rican and she was very old at 75. A Puerto Rican may be physically old at 45.

About eight years ago a reduction in the sugar quota from Puerto Rico to this country brought added hardship to the workers in the sugar industry, and brought a large influx of Puerto Ricans to New York. Their families here, already "on relief," would save enough money for relatives to come up from the island where living conditions were much worse than here. It is easy to see the difficulties of a public relief agency trying to keep up with the size and content of a Puerto

PUBLIC HEALTH NURSING

Rican family at the height of the depression. One month there would be a mother and father and three children, the next month five children, and the next month perhaps seven children. Soon a grandmother or an aunt would be added to the family. She usually visited from one household to another wherever there was a little food, timing her moves so that her absence coincided with the "relief" investigator's presence—so that no one knew just where she belonged. This shelter and protection often went beyond the immediate family. Cousins and friends were harbored and fed until residence had been established when they, too, were eligible for relief.

ALTHOUGH friends and added family from Puerto Rico were much wanted by their own group, the conditions of unemployment and poverty here made their adjustment a difficult one. Even more difficult is the adjustment that the Puerto Rican has to make to other nationality groups in New York. They are not well received. They are a different race, speak a different language. They do not conform to the customs of the neighborhood.

The Italian does not want him for a neighbor. He says, "I am white. I have been in this country for many years (though he may not be a citizen) and these dark-skinned foreigners come to the city and demand their rights as citizens."

The Irish do not want him for a neighbor either. To the Irish they are "Spiks." A "Spik" can't even speak English. His ways of life, though he may call himself a Catholic, are an outrage to the Irish Catholic way of life.

What are some of these customs that are so offensive to their neighbors? How has the Puerto Rican background influenced their attitude toward the common business of living—to food, shelter, clothing, and to family and religion?

Most Puerto Ricans, new in the States, are poor and unwanted so they live in the worst tenements to be found. They are accustomed to low rent, crowding, and taking what comes their way, so they accept it—for a while.

Some of their personal habits are not suited to tenement living. They may have a tendency to spit on the floor. There is no ground handy and they are accustomed to living near the soil. The little children are apt to use the floor for a toilet. It is not customary to control the natural functions of little children. Cockroaches and bed bugs are abundant in warm countries so fit naturally into the Puerto Rican home here. "Ah, Chinchá," they will say and calmly remove a bed bug from sight. There is no need to be disgusted with what, to them, is natural. But with encouragement even the poorest Puerto Rican will admit that he does not like "chinchas" and will work toward their extermination. Head lice are considered very dirty and mothers will work hard to keep their little girls' long black hair clean. Their skin is clean—I have never bathed a dirty Puerto Rican body.

PUERTO RICANS in this country only a short time usually have barren homes and when they acquire furniture often do not know how to take care of it. You will seldom see a big electric refrigerator or a fine gas stove. These things are not so important—any stove cooks rice and beans, and food is usually bought in small quantities making refrigeration less urgent. But a "rahadio"—that is different! If you have the confidence of the family, they will remove the cover that protects that "rahadio" from dust and the relief investigator and play it for you—good and loud. Music is essential. A too-expensive radio is as important to a Puerto Rican as a too-expensive refrigerator to an Italian. The viewpoint is different, that is all.

PUERTO RICAN PATIENTS

Though the Puerto Rican home may be barren, there is an interest in homemaking. When they have possessed enough to learn the care of possessions and have even meager funds, their homes are colorful and attractive. When we consider that our Puerto Rican patient born at the turn of the century may have lived in a house made of cocoanut leaves with a palm leaf roof if he was lucky—for as late as 1910 there were 10,000 homeless children under 12 years of age in Puerto Rico—their adjustment to tenement living is amazing.

I know a very proud and dignified Puerto Rican lady who was a homeless child from the time she was eight years old. She grew up on the beach with other homeless children. She kept herself alive by carrying water in oil cans almost her size at a penny a can. When she was older she washed clothes for pennies. She picked up what fruit and vegetables she could find and managed to keep ahead of starvation. When she was 12 years old she met a little boy 14 and they played together and became lovers. Before she was 13, her first baby was born—in a shed. And so, as her daughter told me, "She became a mother before she became a woman." Her daughter says, "My mother has suffered so much that she does not feel any more." Actually she feels intensely for her children and for any sincere kindness that is shown her. Late one afternoon I heard she had been ill and stopped by to see her. "I am a little sick, but I am all right." What is a little sickness after earthquake, hurricane, and famine? She did not need a nurse but I could feel a deep though quiet joy that I was there—someone really cared for her as a human individual.

Puerto Ricans have been homeless and they have been hungry. They have been hungry from lack of food and hungry from famine. A Puerto Rican friend told

me that before she came to this country she had passed through so many "hungries" all she wanted to do was eat and sleep.

When one has been really hungry, the fact that one *eats* is more important than *what* one eats. If we understand this and that the Puerto Rican in New York will eat, as nearly as possible, the foods he is accustomed to eat at home, we can work with him in building up an adequate diet.

CLIMATE plays an important part in the customs of people, especially in habits of dress. Puerto Rico has a very warm climate and clothing is worn more for adornment than protection. Little children often go unclothed except for a little shirt and this custom is apt to be continued with few concessions to the New York climate when Puerto Ricans come to this country.

An attractive young Puerto Rican mother attended Mothers' Class with her small son about three years old. Invariably at some time during her clinic visit, Pedro would escape and reappear without nether garments. Quickly mother and son would leave the room, soon to return with the missing garments restored. Pedro's expression plainly indicated his disfavor.

The lack of funds to buy clothing and inability to make a quick change in clothing habits, plus poor tolerance for cold weather, plus susceptibility to respiratory infections, mean much winter hardship. Many days are lost at school and a great deal of time is spent in the house that could be spent outdoors if clothing were adequate.

Living in the poorest Puerto Rican home is not just a matter of creature necessities, it is a thing of the spirit as well. You will usually find a loaf of bread over the doorway. This signifies a

PUBLIC HEALTH NURSING

welcome and a hope that there will always be a crust to share. Nor is the family limited by the usual boundaries but includes anyone who needs food or shelter and friendliness. When an American mother of my acquaintance was left temporarily homeless with her five children, it was not a public agency or another American family who first came to the rescue. It was Puerto Rican Mr. and Mrs. Sanchez and their eight children who welcomed this woman and her youngsters into their crowded home.

With the thought of family life comes the question of Puerto Rican names. I had often heard that they do not know their own names. They know, only the custom of naming is different from ours. If unmarried Maria Velez marries Jesus (pronounced Hay-sus) Gonzales she becomes Mrs. Maria Gonzales-Velez. Her children are known as Carmen Gonzales-Velez, Jose Gonzales-Velez, et cetera. On the doorbell one would probably find both Gonzales and Velez. Naturally, if one asks, "What is your last name?" Mrs. Gonzales replies, "Velez." It is better to ask, "What is your husband's name?" or "What is your marriage name?"

It is said, too, that affections are casual among Puerto Ricans, but I have not found this to be the case. There is usually deep devotion between man and woman. I have seen Puerto Rican men tenderly care for their wives during long illnesses. Both women and men show great feeling for little children, though they give them more independence at an early age than we do.

Most Puerto Ricans marry. Many of them, especially if they are devout churchgoers, have large weddings similar to Italian weddings. But civil ceremonies are common and absence of legal ceremony bears little social stigma. American emphasis on the legalities of marriage is particularly puzzling to some of the older

Puerto Ricans. "We live nice together 20 years, we have many children together." Why all the fuss?

Regardless of church affiliation or lack of it, all Puerto Ricans accept God as controlling life and death, hurricane, flood, and earthquakes, the beauty of nature—birds, flowers and stars—all those things which are beyond human control. "Si Dios quiere" (God willing) is always the response to "I'll see you tomorrow."

THE feeling of Puerto Ricans toward medical and nursing service is colored by many influences. There may be fright. I remember one patient, a cardiac, who delivered her baby behind locked doors, without any assistance, because she was afraid to go to the hospital. There may be extreme shyness. I made several visits to one little expectant mother advising her what to tell "one friend who is going to have a baby," before she could bring herself to admit that she was the "friend" in question. There may have been an unpleasant experience with medical or nursing care. If at a clinic a patient hears a derogatory remark about Puerto Ricans, he may not return. It will take many months to reestablish a friendly relationship even though there is dire need for medical care.

Public relief, health department services, and even city hospital care are readily accepted as their legal right as citizens. Puerto Ricans are not long-faced poverty pleaders, but when there is need for assistance they will take aggressive action toward obtaining their lawful due. Assistance must be either lawfully due or the feeling must be right—preferably both. Puerto Ricans are a sensitive people. Too, they have survived so many years with only scant benefits from the medical profession that they feel even without care they will continue to survive, "Si Dios quiere."

PUERTO RICAN PATIENTS

Visits from the nurse are politely received, but actual nursing care may be accepted with reluctance. The services of the nurse are seldom requested by the Puerto Rican families themselves. It would take a long search through many "call slips" to find one call from a Puerto Rican family. Even then the visit would probably reveal, not illness as of primary importance, but a distress of such magnitude that it must be shared by some particular nurse who is a real friend to them.

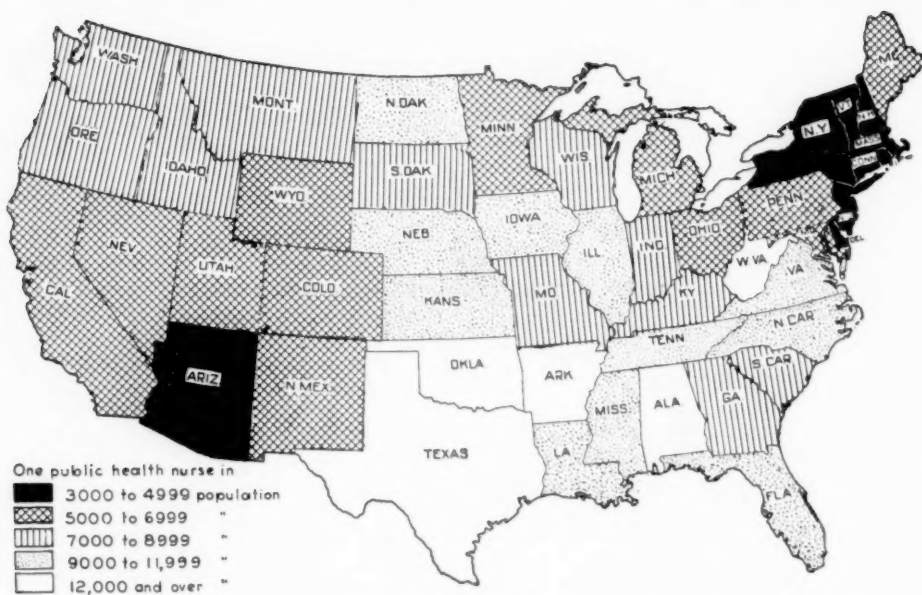
To bring public health nursing to the Puerto Rican people we must take the initiative—first as polite, unhurried visit-

ors, later as understanding friends. When a real understanding has been reached between nurse and Puerto Rican patient, their confidence is at times overwhelming.

One day I visited a family with seven children from 3 to 12 years old, of whom I was very fond. The mother and I talked quietly about each member of the family. Everyone was well but—"I have been very seck. I think I am going to die. I send for my seester to bring a lawyer. I want to sign all my children over to you. I know you give such good care. Now I am better. Thank you very much."

THE AMERICAN JOURNAL OF NURSING FOR MARCH

Pests: Control and Treatment.....	M. Fernan-Nunez, M.D.
Learning to Know People.....	Dorothy Johnson, R.N.
Cancer of the Breast.....	John A. Wolfer, M.D.
Nursing in Cancer of the Breast.....	Eleanor Marie He'm, R.N.
The A.R.C. Blood Donor Service.....	Chas. V. Coggin, Jr.
Salaries of General Staff Nurses.....	
Industry, Women, Safety, and Health.....	Mary Anderson
The Recovery Room.....	Flerence E. Dunn, R.N., and Miriam G. Shupp, R.N.
Naval Hospital in San Diego.....	Mary D. Towse, R.N.



Public Health Nurses in the United States, January 1, 1942

Count of Public Health Nurses, January 1, 1942

THE U. S. Public Health Service has supplied a count of public health nurses in the States each year since 1937, a continuing record particularly useful in these years when nurse power is a commodity essential to successful waging of war both on the Home and Battle Fronts.

As of January 1, 1942, the U. S. Public Health Service count shows 21,123 public health nurses employed, exclusive of industrial nurses. Their number being extremely difficult to determine, the latter were not included in the 1942 figures. Of the 21,123, national agencies and universities employed 145, and 495 were employed in Alaska, Hawaii, and Puerto Rico. This leaves 20,483 public health nurses employed for local duty in the States.

Table I shows the distribution of these 20,483 nurses by districts as outlined by the U. S. Census Bureau. About 30 percent were employed in the Middle Atlan-

tic States, and almost 20 percent in the East North Central States. Thus almost half of the nurses were employed in 8 states. The 8 states, however, account for about 40 percent of the total population.

It is evident that the distribution of public health nurses by population is uneven. Table I shows that New England has the greatest number in proportion to the population and the West South Central States have the lowest. The West South Central States are Arkansas, Louisiana, Oklahoma, and Texas.

The map shows the distribution of public health nurses by states. There are 9 states which show a ratio of 1 nurse in from 3,000 up to 5,000 population; 12 states, 1 to 5,000-7,000; 11 states, 1 to 7,000-9,000; 11 states 1 to 9,000-12,000; 5 states, 1 to 12,000 and over population.

The 1942 count of public health nurses presented by the U. S. Public Health Service gave data about certain qualifica-

COUNT OF PUBLIC HEALTH NURSES

TABLE I
PUBLIC HEALTH NURSES ON DUTY¹ AND POPULATION² PER NURSE, 1942

Districts ³	Population estimated as of May, 1942 ²	Public health nurses ⁶	
		Number	Persons per nurse
United States, total	134,400,000 ⁴	20,483 ⁶	6,562
New England	8,644,861	2,228	3,880
Middle Atlantic	27,733,858 ⁵	6,095	4,550
East North Central	27,766,661	3,859	7,195
West North Central	13,384,335	1,584	8,450
South Atlantic	18,495,579	2,289	8,080
East South Central	11,033,566	1,108	9,958
West South Central	13,430,214	1,021	13,154
Mountain	4,084,938	662	6,171
Pacific	10,262,046	1,637	6,269

¹ Data from release of U. S. Public Health Service: "Total Number of Public Health Nurses Employed in the United States . . . on January first of years 1938, 1939, 1940, 1941, and 1942."

² Population figures by states from December 1942 issue of *Journal of the American Statistical Association*, p. 437, "Preliminary Population Estimates Based on Ration Book Applications."

³ Districts according to U. S. Census Bureau groupings.

⁴ Total population is not sum of district populations, but is based on increases of births over deaths since census of 1940.

⁵ Middle Atlantic figures are not available in Ration Book data.

⁶ Exclusive of industrial nurses, those in national agencies and universities, and those in outlying areas.

tions, such as completion of an approved public health nursing program of study, high school graduation, and college graduation. This material does not appear in printed form, and in response to many requests, it seems desirable to summarize some of it in PUBLIC HEALTH NURSING "for the record."

TABLE II
NUMBER AND PERCENTAGE OF PUBLIC HEALTH NURSES WHO HAD COMPLETED ONE OR MORE YEARS IN AN APPROVED PUBLIC HEALTH NURSING PROGRAM OF STUDY: DATA AS OF JANUARY 1, 1942

Districts ¹	Total number on duty	Those who had completed one or more years in an approved public health nursing program of study	
		Number	Percent
United States and outlying areas	20,978 ³	5,792	27.6
New England	2,228	494	22.2
Middle Atlantic	6,095	1,261	20.7
East North Central	3,859 ⁴	1,127	29.2
West North Central	1,584	534	33.7
South Atlantic	2,289	587	25.6
East South Central	1,108	238	21.5
West South Central	1,021 ⁴	212	20.8
Mountain	662	340	51.4
Pacific	1,637 ⁴	863	52.7
Outlying areas ²	495	136	27.5

¹ Districts according to U. S. Census Bureau groupings.

² Alaska, Hawaii, and Puerto Rico.

³ Exclusive of industrial nurses, and those employed by national agencies and universities.

⁴ In these areas there were a few nurses for whom qualifications data were not complete.

PUBLIC HEALTH NURSING

Of the 20,978 employed in the states and outlying areas, 27.6 percent had completed one or more years in an approved public health nursing program of study. The Rocky Mountain and Pacific States were far ahead of the countrywide average so far as such preparation was concerned. In these districts over 50 percent of the public health nurses reported the completion of a year's study. The lowest percentage was reported in the Middle Atlantic States, in which district only 20.7 percent reported the completion of a year's study. It is known that requirements for appointment vary. The last

N.O.P.H.N. salary study* showed that salaries were higher in the Farwestern States for nurses in official agencies, and also for generalized staff nurses in non-official agencies.

The comparisons afforded in these two tables present again the problems of adapting the supply of public health nurses to the civilian needs of the population.

—DOROTHY E. WIESNER

* Wiesner, Dorothy E., and Murphy, Margaret M. "Salaries in Public Health Nursing, 1942." *PUBLIC HEALTH NURSING*, December 1942, p. 690.

REFERRAL FORMS

DISCRIMINATE prompt referral and reporting between agencies operate to the great advantage of the families served and contribute much to the efficiency of service of the agency." This sentence appears on page 21 of the May 1942 booklet of the National Nursing Council for War Service, "Distribution of Nursing Service during the War."

A number of state health departments have prepared printed forms to refer mothers and infants from hospitals to public health nursing agencies. The most recent received at N.O.P.H.N. comes from the Connecticut State Department of Health. Its title is "Referral to Public Health Nurse for Postpartum and New-born Care." It is a half sheet of paper on which pertinent information may be supplied by the hospital or physician to the public health nurse. The U. S. Children's Bureau has recommended such a form in accord with its aim of securing more adequate care for mother and baby in his first days of life.

The N.O.P.H.N. will be interested to receive recent referral forms from other states and counties or news about other devices for coordinating the work of community health agencies.

Body Mechanics and Posture: A Program of Staff Education

By FLORENCE L. PHENIX, R.N.

THE PRACTICAL application of the mechanics of motion to the needs of the individual is a responsibility not limited to a nursing specialty. It is part of physical therapy, of physical education, and of all phases of nursing care and supervision. Much of the emphasis which has hitherto been placed upon skeletal anatomy and kinesiology has been from the standpoint of care of orthopedic patients. The application of this information to all health supervision and nursing care is of fundamental importance in the prevention of disabilities, and in the reduction of the time necessary for convalescence from conditions of non-orthopedic nature. Consistent attention to this will aid individuals in the conservation of their strength, the maintenance of health through the effect on circulation, digestion, and elimination, and the prevention of deformity or disability due to faulty position.

The outline which follows suggests possible content for an institute or refresher course, or staff education program in orthopedic nursing. The manner in which it is used will depend upon the size of the agency or combination of agencies, and the type of nursing services provided. Examination of community resources may further modify the amount of time an agency may wish to devote to staff education in orthopedics, and may assist in planning the program to meet community needs more adequately.

OBJECTIVES

The central objective is to acquire the ability to apply the principles of body mechanics and posture to general nursing care and health supervision, in order to prevent or limit the extent of disability.

Contributory objectives are:

1. To gain understanding of normal growth and development of bones.
2. To gain understanding of the structure and normal function of joints.
3. To gain understanding of the function of muscles.
4. To develop an awareness of normal position of the body in repose and in activity.
5. To develop understanding of muscle action in relation to everyday activity.
6. To develop the ability to recognize slight deviations from the normal so that these may be brought to the attention of the physician before disability occurs.
7. To gain understanding of the relation of injury, illness, or defect, to normal joint and muscle function of not only the part affected but of the entire body.
8. To acquire the ability to recognize and modify situations which may influence or contribute to the development of orthopedic defects.

PROBLEMS

There is value in examining specific problems recognized by the individuals in

the group, in order that the material presented may be thoughtfully related to expressed needs of the group. The problems should be problems of the nurses—not of the instructor or group leader. Following are a few questions raised by nurses providing service of a non-orthopedic nature:

How may we more readily recognize early deviations from the normal function of the extremities, head, neck, or back?

The individual with temporary mechanical restriction often has difficulty in walking following a period of bed rest. How may we reduce the delay in recovery when such delay is due to limitation of motion in knees, ankles, or hips, caused by inactivity and maintenance of mechanically poor position over a period of time?

The occurrence of back deformities among school children presents a problem. How may these be detected early? What constitutes a back deformity? What causes these? Is there correction or adjustment of home or school routine which may help prevent development of these defects?

The individual with residual disability after all possible correction has been accomplished often needs assistance. How may we best guide in the compensatory use of other muscle groups? How may we help the individual attain the maximum amount of functional efficiency in the face of handicap?

Parents often wish to discuss the comparative advantages and disadvantages of orthopedic surgery recommended for a child. These recommendations may involve the elimination of motion from one or more joints with definite points both for and against. The deciding factors are usually the functional advantages to be determined in the light of possible occupation, unless, of course, it is indicated for the control of an infectious process.

The adjustment of home facilities to meet the needs of the chronically disabled must be approached from the standpoint of:

1. The social needs of the individual. How can he be made independent within the limits of his handicap?
2. The physical needs of the patient. Will certain adjustments of home facilities encourage development of any deformities? If so, will this be of any disadvantage to the patient? Is it sacrificing a motion which the patient could use to advantage?

DEVELOPMENT OF OBJECTIVES

1. *To gain understanding of normal growth and development of bones.*

Factual information to include:

Function of bones—support, protection, muscle attachment points.

Growth of bones—development, composition of bone tissue, nutrition, blood supply, innervation.

Joints—classification, function, structure.

Activities:

Examination of charts, models, skeleton, and self, for location and function of bones, and joints.

Obtain necessary information from text and reference sources relative to bone structure and composition at various stages of prenatal and postnatal development.

Discussion, class demonstration, and class practice would be used.

Evaluation:

Student should be able to identify and describe identifying landmarks on bones of:

upper arm
forearm
thigh
lower leg

pelvis
shoulder girdle
spine
thorax

Student should know:

- structure of bone tissue
- source of blood supply and of nerve supply
- changes in the composition of bone which take place during:

prenatal period	adolescence
infancy	old age
childhood	

Student should be able to relate knowledge of composition and development of bone to theory underlying:

- cast correction of club feet in the infant
- development of deformity through prolonged maintenance of one position
- changing shape of baby's head

2. To gain understanding of the structure and normal function of joints.

Factual information to include:

- Classification, location, and function of joints
- Joint structure
- Normal range of motion for each joint

Activities:

Selection of cases for demonstration of:

- Normal joint motion—include for demonstration purposes all joints having to do with locomotion, use of arms and hands, and any other joints which affect competitive activity.
- Disability—demonstration to illustrate varying degrees of handicap and the extent to which compensation can be accomplished.

Through reading and practice, develop ability to analyze extent of disability caused by total or partial loss of motion in one or several joints. The extent of disability should be estimated in relation to employability in:

- | | |
|-------------------------------|--------------|
| sedentary type of office work | labor |
| nursing | mine work |
| teaching | factory work |
| farming | other |

Evaluation:

Student should know:

- Knee, hip, shoulder, and elbow joints, and should be able to describe these.
- Normal range of motion of knee, hip, shoulder, and elbow joints, and should be able to demonstrate this for each joint.
- Ligaments of these joints and be able to identify them and give their importance or function.
- General structure and plan of ligamentary reinforcement for spine, pelvis, fingers, wrist, and ankle.

Student should be able to relate knowledge of normal range of joint motion to functional needs in everyday activities.

3. To gain understanding of the function of muscles.

Factual information to include:

- Name, location, and action of muscles of the extremities
- Name, location, and action of muscles of the trunk
- Blood supply of these muscles
- Innervation of these muscles

Activities:

Through reference material, charts, and other sources secure information regarding the origin, insertion, and action of muscles indicated above.

Through practice on self and other models, become familiar with location and function of various muscles.

Through reference material, charts, and other sources secure necessary information regarding the blood supply and innervation of these muscles.

PUBLIC HEALTH NURSING

Evaluation:

Student should know:

Origin, insertion, action, innervation, and blood supply for the muscles of the upper and lower extremities, back, abdominals, shoulder girdle, and neck—with a few specified exceptions of smaller muscles in back, neck, feet, and hands.

4. *To develop awareness of normal position of the body in repose and in activity.*

5. *To develop understanding of muscle action in relation to everyday activity.*

Factual information to include:

Distribution of body weights—normal and abnormal.

Relation of this to:

balance

chest capacity

digestion

fatigue

circulation

elimination

Function of feet, joints of lower extremities, and back, in standing, sitting, and walking.

Muscle action in relation to chest capacity and the support of abdominal and pelvic organs.

Position of joints and distribution of body weight in good weight bearing position.

The foot structure and use in weight bearing and activity.

Activities:

Obtain necessary information from anatomy and kinesiology texts.

Demonstrate and explain good and poor posture. Explain the cause of strain and fatigue in poor posture.

Determine the postural changes normal to a woman in the course of pregnancy.

Develop a demonstration chart to illustrate the shifts in weight bearing position necessary to meet the changes in distribution of body weight.

Analyze normal posture in the standing, recumbent, sitting, walking, and stooping positions.

Analyze normal posture in the infant, pre-school child, adolescent, and adult.

Evaluation:

The student should be able to relate variations in posture to:

fatigue

chest capacity

circulation

digestion

elimination

support and position of abdominal and pelvic organs

Should be able to relate factual information to demands of activities such as:

walking on the level

feeding self

walking up stairs

combing hair

rising to standing position

sawing wood

sitting down

digging with shovel

6. *To develop the ability to recognize slight deviations from the normal so that these may be brought to the attention of the physician before disability occurs.*

Factual information should include:

Shape, placement, and function of bones

Growth, development and composition of bones

Kinds, location, and function of joints

Location and action of muscles (skeletal)

Mechanics of motion—locomotion and other activity

Function of bones, joints, tendons, ligaments, and muscles in relation to motion and to stability

Normal distribution of body weight

Activities:

Attend clinics for observation.

Obtain from reading and other sources, all possible information regarding the physical characteristics and activities of the normal child. Supplement this by practice in observation of children in whatever service the nurse is working.

Select series of cases for study and analysis of:

mechanical nature of the disability

possible causes of the handicapping nature of the disability (mechanical)

BODY MECHANICS AND POSTURE

nursing techniques which may have promoted or encouraged its development
nursing procedures which might have controlled or reduced the severity of the disability
Analyze strains upon the body mechanism in adapting to meet the demands of:
excess weight due to excess fat
excess weight due to pregnancy
ill fitting shoes
chairs of faulty construction (designate points at fault)
incorrect posture in desk work
scoliosis
arm disability
disability of lower extremity
other disabilities which may modify the function of some part of the neuro-muscular system

Evaluation:

Student should know:

- What is meant by normal distribution of body weight.
- What change in distribution occurs in pregnancy.
- Through what points the body weight is normally supported.
- Where the center of gravity should fall.
- What causes strain in faulty posture.
- What changes occur in the posture normal to:
 - an infant
 - a pre-school child
 - an adolescent

Should be able to relate this information and other information previously obtained to:

- Posture of the child—in order to detect early deviations from normal so that any necessary preventive or corrective program may be started early.
- Gait of the child—in order to detect beginning limps which might be indicative of early bone lesion or the development of some other abnormality which might be prevented or controlled if detected early.
- Other deviations which might indicate possible orthopedic or neurological conditions which if located in the early stage, might be controlled or prevented from developing into serious handicap.

7. To gain understanding of the relation of injury, illness, or defect to normal joint and muscle function of not only the part affected, but also of the entire body.

Factual information should include:

That designated under previous objectives, with particular emphasis on 4, 5, and 6.

Activities:

Secure from anatomy and physiology reference sources, an understanding of the relation between skeletal position and muscular support of abdominal organs. Also compare good and poor chest capacity.

Analyze the relation between normal weight distribution and the adaptations necessary for balance and good weight bearing position with impaired function of one or more members.

Study series of medical and surgical cases *for the purpose of observing:*

- complaints of patient when first ambulatory
- type of gait
- length of time before complaints disappeared

and for the purpose of analyzing:

- the reason for complaints
- the reason for difficulty in locomotion

with the desire to determine possible modifications in nursing care in order to:

- reduce number of complaints registered by patients
- reduce the length of time required for disappearance of complaints

Evaluation:

Student should know:

- Name, location, action of muscles of shoulder girdle, chest, back, and abdomen.

PUBLIC HEALTH NURSING

What motion is possible between ribs, sternum, and spine.

What changes are made in the lateral, and antero-posterior measurements of the chest cavity, and in the circumference with change in rib position.

How changes in chest position may affect circulation.

Changes in weight bearing posture which would be necessary to compensate for the following abnormalities:

- kyphosis
- bilateral hip flexion contractures
- bilateral knee flexion contractures
- shortening of the leg on one side

8. *To acquire the ability to recognize and modify procedures and situations which may influence or contribute to the development of orthopedic defects.*

Factual material:

That designated under previous objectives, with particular emphasis on 4, 5, and 6.

Activities:

Obtain information from reference sources regarding the influence of fatigue on posture.

Examine cots of various types for good and poor features.

Examine school desks and seats and indicate manner of adjustment to individual needs.

Obtain information from reference sources, regarding shoes and the points to be noted in fitting shoes for a:

- | | |
|-------------------|------------------|
| 1-year-old child | 16-year-old girl |
| 6-year-old child | an adult |
| 12-year-old child | |

Examine bed position of a number of patients and note the points of good and poor posture.

Determine the cause of the points of poor body alignment and the method of correction.

Examine the complaints such as those reported under 7, and suggest possible measures for prevention of such difficulties.

Evaluation:

Explain points to note in determining adequacy of school seats and desks from the standpoint of posture.

Points to note in purchasing shoes for a child and for an adult.

What should determine the adequacy of a bed; and how may a poor one be modified satisfactorily.

Demonstrate support for good bed rest position, back, side, and face lying.

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PREPARATION FOR SUPERVISION

IN A PRELIMINARY report on "A Survey of Courses in Supervision in Colleges and Universities Offering an Approved Program of Study in Public Health Nursing, 1941-1942," a dissertation for master of science in nursing education by Winifred Devlin at Catholic University of America, a number of interesting facts are revealed. This study included 26 of the 31 colleges and universities offering an approved program of study in public health nursing in 1941-42. The data were obtained from a questionnaire and from the bulletins of those colleges and universities.

Miss Devlin found that courses in supervision were first introduced in 1920; but the majority of them date from 1937.

Eighteen of the 26 schools offered courses in supervision. Of these 18, four offered a program of study in supervision; the other 14 offered only isolated courses. Completion of a program of study in public health nursing, and experience in public health nursing are prerequisites to most courses in supervision. Programs of study in supervision show some degree of uniformity in major course requirements. Isolated courses in supervision vary as to title, content, and credit, and the number of such courses offered by the schools differs. Seven of the 18 schools offered courses in field experience in supervision. Four of these were those which offered a program of study in supervision.

NURSE PLACEMENT SERVICE



announces the following placements from among appointments made in various fields of public health nursing. As is our custom consent to publish these has been secured in each case from both nurse and employer.

PLACEMENTS

*Mrs. Edna S. Gould, public health nurse instructor, Indiana University, Bloomington, Ind.

*Helen Tepper, educational director, Visiting Nurse Association, Evanston, Ill.

Gladys A. Lee, generalized supervisor, Providence

District Nursing Association, Providence, R. I.

*Lucille A. Wallis, supervisor, Instructive Visiting Nurse Society, Washington, D. C.

*Mrs. Mamie T. Klayman, field nurse, Tice Clinic, Chicago, Ill.

*Dorothy Louise Perkins, staff nurse, Tuberculosis Institute of Chicago and Cook County, Chicago, Ill.

Georgia Frances Manush, industrial nurse, Chicago Metal Hose Corp., Maywood, Ill.

Geraldine J. Chadbourne, staff nurse, Lorain County District Health Department, Oberlin, Ohio.

*The N.O.P.H.N. files show that this nurse is a 1942 member.

Reviews and Book Notes

WOUNDS AND FRACTURES

By H. Winnett Orr, M.D. 228 pp. Charles C. Thomas, Springfield, Illinois, 1941. \$5.

During World War I many observations were made in treating the wounded when time was at a premium and the demands great. The intervening years have brought more consideration of these observations, and World War II is bringing forth a re-evaluation of results and methods of treatment of the injured. We have read and heard a great deal about the success of the Orr treatment for fractures and osteomyelitis. Therefore, this recent publication is particularly timely in the present crisis.

The book is written primarily for the medical profession as "a clinical guide to civil and military practice." Nevertheless, the nurse should be interested in and familiar with procedures and should have an appreciation of the end results desired. Only then can she become skillful in providing the nursing care needed.

Many memorable case reports are described accompanied by splendid illustrations. Dr. Orr explains his method of treatment in a simple direct manner, explaining the fundamental principles of fracture treatment and progressing to the control of complicated fractures according to the part of the anatomy involved and severity of the injury. His cardinal points of treatment consist of correcting position, providing drainage if necessary, immobilization, and protection from further infection. One of the outstanding characteristics of the Orr treatment is the infrequent dressing or no dressing procedure. The chapter, First Aid, Medical Care and Physiotherapy, contains valuable directions and warnings to the first aider, the nurse and the physiotherapist.

The reports of the results achieved by the application of this method are most

encouraging. The relief of suffering and the lessening of disability for the patient are primarily important. The conservation of time afforded the attending staff and the economy of surgical supplies are welcomed.

This book should be interesting and instructive to all of us as it contains a rich store of valuable information for the institutional nurse, the public health nurse, and the physical therapy nurse.

LUCY E. BLAIR, R.N.
Madison, Wisconsin

WAR MEDICINE

Edited by Winfield Scott Pugh, M.D. 565 pp. Philosophical Library, Inc., New York, 1942. \$7.50.

This volume which is comprised of 57 individual contributions by British and American authorities gathers together at an opportune time much valuable information on numerous aspects of war medicine. Some of the material concerns experiences in the present war, particularly that contributed by the British authors; some concerns observations made in World War I. In addition to the major portion of the book which deals with Surgery, consideration is given to Aviation and Naval Medicine, and General Medicine.

Even though carefully edited, some of the unavoidable difficulties inherent in assembling contributions, already presented elsewhere by different authors, are evident in this book. Lack of uniformity of approach and performance by the various authors, as well as reduplication of certain phases of the material covered, are examples.

The specific types of war injuries are for the most part well covered. The presentations dealing with shock, blood substitutes and plasma protein are excellent. There is much valuable information in

BOOK NOTES

the portion of the book which deals with the physiologic aspects of high altitude flying and deep sea diving. The section devoted to General Medicine covers only a few of the medical problems peculiar to war. Those interested in the cardiovascular and psychiatric examination of Army recruits will find helpful suggestions in the papers on these subjects. Some of the contributions contain extensive bibliographies.

It is the reviewer's opinion that physicians called upon to treat civilian war casualties as well as those in the armed forces will find much useful information in this book. The lack of an index will, however, seriously interfere with its use for reference purposes.

KARL J. THOMSON, M.D.
Washington, D.C.

ORTHOPEDIC NURSING: CONTENT AND METHOD OF THE TEACHING PROGRAM IN SCHOOLS OF NURSING

By Carmelita Calderwood, R.N. Joint Orthopedic Nursing Advisory Service, 1790 Broadway, New York, 1942. Single copies free.

Written with knowledge and understanding, Miss Calderwood's pamphlet constitutes a challenge to all nurses, but especially to nurses responsible for the education of the student nurse. Throughout the book emphasis is placed on the process of integration and teaching orthopedic implications in all nursing services as they present themselves to the student in actual nursing situations. Orthopedic nursing techniques are recognized as basic to any good nursing care. The introduction of technical terminology is timely and indicative of the trend in lay medical education. A practical and usable guide is presented in the 22-hour course outline.

With such an all-inclusive course during her undergraduate years, the graduate would be well prepared to function as an orthopedic staff nurse in either the hospital or the public health field. Such a basic course would give the nurse a sense of related values that is essential in find-

ing a way to integrate the specialties with the generalized or family health service.

MARY FERGUSON, R.N.
Indianapolis, Indiana

ESSENTIALS OF NURSING

By Helen Young, R.N., and Associates of the Presbyterian Hospital. Edited by Eleanor Lee, R.N. 609 pp. G. P. Putnam's Sons, New York, 1942. \$3.

Miss Young and her associates have collaborated to produce this book which is essentially a textbook for courses in nursing arts.

In the Introduction—Nursing: Art, Science, Profession—the authors point out the need for nurses who are skilful of hands, equipped with the latest scientific knowledge, and possessed of sympathetic understanding of human beings in order that they may meet their increasing responsibilities for helping individuals regain and maintain health. This book is aimed at the development of such nurses.

The material is presented in three parts. Part I is concerned with Basic Nursing Care; Part II is a discussion of The Role of the Nurse in Diagnostic and Therapeutic Procedures; while Part III is a timely and helpful consideration of The Role of the Nurse in Emergencies.

Although application of procedures and care to various medical conditions is made, the value and usefulness of the book lies in the major emphasis being placed upon underlying principles rather than upon the details of a way of doing. One is gratified, too, to note that stress is placed upon the need to know the patient, his background, his economic conditions, his likes and dislikes, so the plan for his care may be made for him—the individual.

Because of its scientifically based principles, its clearness of presentation and its timeliness, the book will be a useful and valuable reference book for public health nurses.

DOROTHY MCKEE, R.N.
Philadelphia, Pennsylvania

PUBLIC HEALTH NURSING

RECENT PUBLICATIONS AND CURRENT PERIODICALS

WARTIME

AMERICA'S FUTURE. Fern Long, Ph.D. American Library Association, 520 North Michigan Avenue, Chicago, 1942. 8 pp. 25c; \$1 per 10 copies.

This is the second of a series of reading lists, compiled at A.L.A. request by Dr. Long of the Cleveland Public Library.

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RECREATION AND HOUSING FOR WOMEN WAR WORKERS: A Handbook on Standards. Mary V. Robinson. U. S. Women's Bureau Bulletin No. 190. Available from the Superintendent of Documents, Washington, D.C., 1942. 40 pp. 10c.

"WHY HAVE FEARS?" Milton E. Kirkpatrick, M.D. *National Parent-Teacher*, 600 South Michigan Boulevard, Chicago, November 1942, p. 8. Single copy 15c.

MANPOWER: A SUMMARY OF THE BRITISH EXPERIENCE. Eric H. Biddle. Publication No. 84 of the Publications Division, Public Administration Service, 1313 East 60 Street, Chicago, 1942. 28 pp. 75c.

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MATERNITY AND INFANT CARE

TWO PAMPHLETS available from the Planned Parenthood Federation of America, Inc., 501 Madison Avenue, New York. Free to registered nurses upon request. A list of other available literature may be obtained from the Federation.

Review of Recent Progress: The Aims of Birth Control and Their Place in Preventive Medicine. Nicholson J. Eastman, M.D. Reprinted from *New International Clinics*, Vol. 1, Series 5, 1942. 36 pp.

Techniques of Conception Control. Robert Latou Dickinson, M.D., assisted by Woodbridge E. Morris, M.D. Second edition, 1942. 56 pp.

COMMUNICABLE DISEASES

A STUDY OF THE PUBLIC'S KNOWLEDGE AND ATTITUDE REGARDING CERTAIN INFECTIOUS DISEASES AND IMMUNIZATION AGAINST THEM. Conducted by Elmo Roper. Medical Division, Sharp & Dohme, Inc., Philadelphia, 1942. 31 pp.

"COLDS AREN'T TRIVIAL." Donald B. Armstrong, M.D. *The Journal of the National Education Association of the United States*, 1201 Sixteenth Street, N.W., Washington, D.C., November 1942, p. 245.

NOTES from the NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

REPORT OF THE ANNUAL BOARD MEETING

DESPITE DIFFICULTIES of wartime travel and the necessary absence of several members because of illness or the demands of military service, 22 of the 30 members of the N.O.P.H.N. Board attended the annual meeting held on January 22, 1943. In addition representatives of 18 state branch organizations were present.

For the first time the meeting was held in the N.O.P.H.N. conference room at 1790 Broadway instead of in a hotel. Though the room was filled to overflowing, everyone seemed satisfied with this war economy.

Mrs. Charles S. Brown, second vice-president, presided during most of the session in the absence of both president and vice-president.

Reports to the Board from the treasurer, the Finance Committee, and the Council of Branches are summarized elsewhere in this number of the Magazine. A budget for 1943 was approved which shows an anticipated deficit of \$19,197. This is on the basis of estimated current income equalling \$110,000 and estimated expenditures of \$129,197. Since the N.O.P.H.N. has sufficient reserve funds to meet this deficit, it was the opinion of the Board that there should be no reduction in service during this critical year when extraordinary demands are being made on public health nursing.

Special interest was shown, therefore, in the report of the Membership Committee because it is believed the organization must depend for increased income very largely upon augmenting the number of individual and agency members. Each

state will have both a nurse and a lay membership representative this year. The new class of membership called "Sustaining Member" will be emphasized. The Membership Committee believes that the increasing number of volunteers now serving in public health nursing agencies can be interested in N.O.P.H.N. membership.

Space permits scarcely more than a listing of the many section and committee reports heard during the day. These reports include the following plans for the coming year:

1. A program for publicizing public health nursing will be planned by the Board and Committee Members Section.

2. Preparation of a handbook on industrial nursing will be the project of the Industrial Nursing Section.

3. Immediate objectives of the School Nursing Section will be to discover the percentage of school nurses who are members of the N.O.P.H.N., find out the urgent problems of school nurses, and lend assistance in solving these problems.

4. For the Joint Orthopedic Nursing Advisory Service the principal new undertaking will be to give demonstrations and consultant service concerning the nursing and muscle-re-education aspects of the Kenny Method.

5. The Publications Committee has many ideas for improving PUBLIC HEALTH NURSING Magazine which it is hoped will please its readers.

6. The Education Committee has appointed regional study groups that will consider with the Committee various educational problems. The Subcommit-

tee on Accreditation plans a thorough examination of material in the first yearly review of programs of study in public health nursing, a re-evaluation of the programs of study, a shaping of policies on accreditation and the publication in the Magazine of these policies and procedures.

7. The Committee on Nursing Administration will complete two pieces of work begun in 1942: (1) a study of nursing service in clinics (2) a study of resources and needs for nursing care of the sick in their homes. The fullest use of findings of the latter to promote such services where needed is the most important next project of the Committee.

8. The Council on Maternity and Child Health was commissioned by the Board to set standards for public health nursing services in day-care centers and to give consideration to the problems of the nurse-midwife.

9. The Advisory Committee on Vocational Counseling which has been inactive for some time will be revived this year to consider problems of recruitment of nurses for the public health field and opportunities for placement of public health nurses, in relation to the proposed Nurses Supply Board in the War Manpower Commission.

10. A special committee will develop a guide on preparation and use of volunteers to assist public health nurses in homes.

11. A council will be formed this year for study of the problems of education and employment of Negro public health nurses.

Throughout the day there was much discussion of the many difficulties facing public health nursing. Discussion centered around the shortage of nurses, the urgent needs of the military services, the drawing of public health nurses from all other fields into industry and the neces-

sity to maintain essential civilian health services during the war period, especially in areas with special problems caused by rapidly increasing population around war industries or military camps.

The Board is pleased to announce that Dr. Ernest L. Stebbins, health commissioner of New York City, has accepted the invitation to become a member of the Board and of the Executive Committee. This appointment was made to fill a vacancy.

RUTH HOULTON, R.N., SECRETARY
N.O.P.H.N. BOARD OF DIRECTORS

IN THE FIELD

Because of wartime restrictions on travel, N.O.P.H.N. field service may be somewhat limited for the present, but the Organization is hoping to compensate for this necessary reduction by stepping up activities at headquarters to meet new problems arising from the emergency. Recent excursions into the field have been concerned in some way or other with strengthening public health nursing on the home front.

U. S. CHILDREN'S BUREAU COMMISSION ON CHILDREN IN WARTIME, Washington, D.C., February 4—Ruth Houlton attended this meeting at The White House to discuss the problem of juvenile delinquency which is always a camp-follower of wartime conditions. Mrs. Roosevelt spoke on the care of children in Great Britain. The need for local understanding and pooling of all community resources was stressed by many speakers . . . INSTRUCTIVE DISTRICT NURSING ASSOCIATION, Troy, N.Y., February 11—Ruth Fisher was guest speaker at the Association's annual luncheon meeting, discussing "Public Health Nursing on the Home Front." . . . GROUP SERVICES BRANCH, OFFICE OF PRICE ADMINISTRATION, New York, N.Y., February 17—Mary E. Shaw attended a regional meeting of this Branch of the OPA together with representatives

of about 25 national organizations, at which time the new system for food price control was explained to facilitate the dissemination of this necessary information among the members and affiliated groups of the organizations represented, also the proposed use of volunteers in local price checking. Public health nurses are an important segment of the population insofar as this program is concerned because of their contact with families in the home. . . . THE VISITING NURSE ASSOCIATION OF SCRANTON AND LACKAWANNA COUNTY, Pa., February 18—Ruth Houlton spoke at the annual meeting of the Association on the subject of "Public Health Nursing in Wartime." . . . THE VISITING NURSE ASSOCIATION Poughkeepsie, N.Y., February 25—Ruth Fisher gave advisory service to this organization and in addition, attended a meeting of their Board.

GOOD NEWS ON SHOES

Word comes from Washington that after a nurse has used her stamp 17 in the purchase of new shoes, she can get priority for other new pairs as needed by asking her employer for a certificate and taking this to the local rationing board at the time she makes application.

FREE TO READERS

Due to lack of storage space we must dispose of some of the back numbers of PUBLIC HEALTH NURSING magazine. As long as they last we will be happy to give them to anyone who can use them for the cost of transportation only. This charge is about five cents per issue or in quantity somewhat less. The following are available: 1939, March through December; 1940, February through December except September and October; 1941, March through December except October and November; 1942, April through November. This offer holds good until April 10. Orders will be filled as received.

N.O.P.H.N. INCOME AND EXPENSE 1942

Income

Membership dues, individual.....	\$ 33,049.00
Membership dues, agency.....	29,057.97
Contributions	17,332.00
*PUBLIC HEALTH NURSING magazine	27,619.71
Reimbursements	3,305.99
Biennial Convention.....	4,771.70
National Foundation for Infantile Paralysis	32,236.79
Miscellaneous	9,871.38
Total income	\$157,244.54

Expense

Correspondence and Consultation..	\$ 27,787.29
Field Service	19,368.31
Educational Service.....	11,917.09
Statistical Service and Studies.....	11,094.66
*PUBLIC HEALTH NURSING magazine	
a. Advertising	3,661.36
b. Preparation	8,686.47
c. Printing	8,905.02
d. Subscriptions	7,899.68
Publications and Bulletins.....	12,614.58
Biennial Convention	5,613.23
National Nursing Council for War Service	154.93
Industrial Nursing Manual.....	574.73
Clinic Studies	2,468.24
Study of Nursing Resources.....	2,376.74
National Foundation for Infantile Paralysis	32,236.79
Total expense	\$155,359.12

Summary

Income	\$157,244.54
Expense	155,359.12

Income over expense **\$ 1,885.42**

*PUBLIC HEALTH NURSING Magazine

Income

Subscriptions	\$20,648.21
Advertising	6,971.50

Total income **\$27,619.71**

Expense (allocated)

General administration.....	\$15,436.75
Travel	37.94
Printing and miscellaneous expense	12,633.40
Subscription promotion.....	1,044.44

Total expense..... **\$29,152.53**

Summary for magazine

Expense	\$29,152.53
Income	27,619.71

Deficit **\$ 1,532.82**

State Organizations for Public Health Nursing Meet

THE NEED FOR the S.O.P.H.N.'s and the N.O.P.H.N. to work together in solving mutual problems in wartime was the theme of the fifth annual meeting of the Council of Branches at national headquarters on January 21, 1943. Eighteen of the 21 states which have branches were represented at the meeting. The delegates were: Mrs. Clyde K. Barr, Arkansas; Rena Haig, California; Adah L. Hershey, Iowa; Lula B. McClain, Kentucky; Christine Causey, Louisiana; Eleanor Immler, Maryland; Ethel G. Brooks, Massachusetts; Mabel J. Rue, Michigan; Ann S. Nyquist, Minnesota; Mrs. Elsie Webster, Nebraska; Evelyn T. Walker, New Jersey; Annie Luther, Oklahoma; Aileen Dyer, Oregon; Mathilda Scheuer, Pennsylvania; Mrs. Mildred Hatton, Rhode Island; Claire McGuire, Texas; Anna R. Moore, Washington; Doris Kerwin, Wisconsin.

Attending also were Mrs. S. Emlen Stokes, chairman, Board and Committee Members Section; Mrs. Walter G. Farr, chairman, Lay Section of the New Jersey S.O.P.H.N.; Mrs. Frederick S. Dellenbaugh, Jr., lay member, N.O.P.H.N. Board of Directors; Emilie G. Sargent, chairman, National Membership Committee; Mrs. Elmira B. Wickenden, executive secretary, National Nursing Council for War Service; Marie L. Johnson, acting director, Nursing Bureau, Metropolitan Life Insurance Company; Dr. Calla Van Syckle, member of the Group Services Branch, Office of Price Administration; and members of the headquarters staff.

Miss Houlton welcomed the group in behalf of N.O.P.H.N. and read a message from President Marion G. Howell, who was unable to be present at the meeting.

The Council voted to recommend to the N.O.P.H.N. Board the acceptance of

the Nebraska Branch which had requested membership.

Hortense Hilbert, secretary of the N.O.P.H.N. Committee on Nursing Administration, reported on the progress of the study of the needs and resources for nursing care of the sick in their homes now being conducted by this Committee. Nursing divisions of various Federal and national agencies and the Metropolitan Life and John Hancock Mutual Life Insurance Companies are interested in the study and the Metropolitan Life Insurance Company has made a financial contribution. One public health nursing staff member and additional statistical clerical assistance were assigned to assist with the study. The purpose of the study can be said to be twofold:

1. To find out what provisions for nursing care of the sick exist in communities that have no obvious organized community resources for this purpose, such as public health nursing or visiting nurse associations. The communities selected were without an organized resource.

2. To suggest, based on the study, what patterns of organization might be adopted in such communities that would make it possible to provide nursing care of the sick in their homes.

Miss Hilbert stated that 16 communities were selected for study, varying in size from approximately 10,000 to 120,000 population. In addition, two counties were included. Eleven of the communities had large war industries or military concentrations. The 16 communities surveyed were undoubtedly representative of a much larger number of communities in which similar situations existed. Information previously assembled indicates that 63 percent of all communities from 25,000 to 60,000 popula-

S.O.P.H.N.'s MEET

tion seem to have no organized resource for nursing care to the sick in homes.

Some of the points brought out in the study so far are these:

1. In some communities there are just not enough public health nurses. It was found that the ratios of nurses to population varied from approximately 1 in 3,000 to 1 in 15,000. Only two communities showed the most favorable ratio.

2. A great number of communities reveal an overspecialization of administration—that is, division of administrative responsibility among as many as eight or nine agencies, each of which employs two or three nurses to carry on nursing work.

3. Some communities are not getting the volume or quality of work they should because of organizational and administrative inefficiencies.

4. There is hardly a community among those surveyed that does not present a definite problem of distribution.

Miss Hilbert asked that S.O.P.H.N. representatives help in interpreting the findings of the study so that it would produce maximum results. She asked the group to consider suitable approaches for making known the findings of the study. Especially emphasized was the need for the help of state branches in finding active citizen groups to cooperate with professional groups in better planning of public health nursing services. The representatives voted to go back to their states and try to stimulate, wherever needed and wherever possible, provision and use of nursing care of the sick in their homes.

Miss Sargent, chairman of the National Membership Committee, gave a resumé of the status of agency and individual membership in the organization. In December 1942 there were 313 nonofficial agency members and 25 official agency members. This membership was compared with the total number of agencies employing public health nurses listed by

the United States Public Health Service as of January 1, 1940—namely 1,347 non-official agencies and 4,819 official agencies. It was stated that while there are probably legal reasons for some official agencies not entering into membership, there are others to which such legal restrictions do not apply and which might want to secure the benefits to be derived from agency membership in the N.O.P.H.N. The grand total of individual memberships in December 1942 was 11,091.

The delegates voted to stimulate individual membership, lay and professional, as well as agency membership in their respective states, as part of their contribution to "Strengthen Public Health Nursing for the Home Front."

The need for professional members to keep in close touch with lay members was stressed by Mrs. Farr, who said she believed a well-organized lay group could be of great importance in forwarding public health nursing in any state.

The acute shortage of doctors in some areas brought out the need for keeping standing orders for public health nurses flexible. Marie L. Johnson stated that questions of grave concern from all parts of the country were being received at Metropolitan Life offices.

Some of the questions asked were:

1. Shall nurses give care on the basis of a physician's telephone diagnosis?

2. Shall nurses continue to visit seriously ill patients, even though medical service cannot be secured? In some areas nursing organizations have ruled to discontinue service, if no physician is available, after the second visit. Is this desirable?

3. Shall nurses accept physician's orders transmitted to the nurse by way of the patient?

The Council voted to collect pertinent information in relation to the doctor shortage and the need for reviewing

PUBLIC HEALTH NURSING

standing orders, and transmit this to the N.O.P.H.N. for tabulation and study. It was suggested that state health departments and state medical societies were concerned with this same problem and could give guidance to nursing groups.

The day care of children, another wartime problem of concern to public health nurses, was discussed. Members were urged to participate in communities where day centers were being established. The Council recommended to the N.O.P.H.N. that public health nursing standards for day-care centers be set up by the Council on Maternity and Child Health.

Mary C. Connor, secretary of the N.O.P.H.N. Education Committee, asked the representatives for their help in working with the 11 regional study groups recently appointed by the Committee. Some of the questions placed before these groups for study are:

1. What changes have been made and what changes need to be made in the curriculum? In the light of The Public Health Nursing Curriculum Guide? In the light of the war?
2. Is the orientation period and the staff education program the same, or is it varied, for students? Permanent appointees? Temporary workers?
3. What kinds of staff education programs are being planned for the duration?

Such questions as these and many others need to be studied to help in charting a course for the years immediately ahead.

Public health nurses were called upon by Dr. Calla Van Syckle, Office of Price Administration, to promote understanding of the point rationing system as they go among the many people in every community and into the homes of families everywhere.

Mrs. Wickenden discussed some of the current questions concerning the National Nursing Council for War Service. The

organization of state and local councils was reported to be moving ahead much more rapidly now. It is through these councils that local problems could be worked out. For some time there has been a great deal of discussion as to the possibility of having a "corps" for nurses to take its place alongside the W.A.A.C. and W.A.V.E.S., first because students want definitely to be tied in with a government war program and second because they want to join the Army as soon as they finish. Plans for a government sponsored student nurse corps are under consideration, but at this time no definite decision has been reached. It is not believed that the needed 55,000 students can be recruited for schools of nursing this year, and the problem is so acute that people from the educational field have urged the Nursing Council to make a greater effort to reach girls in the colleges.

In summing up her discussion, Mrs. Wickenden said, "I am wondering if the postwar period is not the place we, the public health nurses, will come into our own. Very shortly the Nursing Council will appoint a committee to plan for nursing service after the war in the United States and possibly in foreign countries."

Jessie L. Stevenson reported that J.O.N.A.S., a combination of the orthopedic consultation service of the N.O.P.H.N. and the National League of Nursing Education, has been in operation a little over a year, and is encouraged at the progress made. She reported that a number of states had organized joint committees for carrying on orthopedic activities in their own states and were keeping in touch with the National office. Miss Stevenson asked the states not having such a committee to consider the need for one. She announced that the N.O.P.H.N. will give orthopedic consultation service to local public health nursing agencies, both official and nonofficial, and asked

NURSES HELP TEACHERS

that the delegates help spread this information to communities.

Mrs. Bethel McGrath, the N.O.P.H.N. consultant on industrial nursing, suggested that S.O.P.H.N.'s arrange institutes for industrial nurses in their various states on subjects of vital interest to them, allowing opportunity for discussion.

The officers elected for 1943 were: Adah L. Hershey of Iowa, chairman; and Mildred Lee Hatton of Rhode Island, vice chairman.

Following the meeting the National Organization entertained the guests at tea.

RUTH FISHER, R.N., SECRETARY
N.O.P.H.N. COUNCIL OF BRANCHES

NURSES HELP TEACHERS

IMMEDIATELY following Pearl Harbor, it became apparent that home nursing would have to be taught in the high schools in the State of Washington to meet the defense needs in a target number one area. As a home defense measure, every high school teacher of home economics was asked to include home nursing in her curriculum. The teachers sought assistance from the local public health nurses wherever possible, but many teachers felt the need of further help in attempting this new course.

This need was expressed in the early fall at the Vocational Teachers' Institute to which the state director of public health nursing and a faculty member of the School of Nursing Education at the University were invited. The teachers made their needs known—not only help with content but even more with methods of presentation and laboratory practice.

Recognizing that the home economics teachers are assuming work that in normal peacetimes would be the responsibility of the nursing profession, the University representative at the meeting volunteered some institutes for teachers; the state department of health agreed to provide the leaders with transportation.

The first institute on a roundtable basis was held in a high school centrally situated in the southwest section of the state. There were 20 teachers present from five counties; the local public health nurse supervisor was invited.

Methods of motivating high school girls in home nursing were presented first, with discussion, questions, and further suggestions from the group. The leaders presented an exhibit of suggested texts and references in the home nursing field for source material. Following this the general content of high school home nursing was discussed and suggestions given for class presentation and laboratory practice. The meeting concluded with demonstrations of home nursing techniques, methods of improvising home equipment, utilization of newspapers and ways of keeping 20 to 24 students busy during the practice periods.

The greatest need expressed was for help in teaching communicable disease control in the home. There appeared to be considerable confusion regarding what were acceptable techniques for the home care of the communicable disease patient that could be taught in such a home nursing course. Resources of local nursing assistance for the classes were pointed out. Some teachers in the very rural areas did not see their public health nurse more than once a month and had not recognized that there might be other nurses in the area, and that staff nurses in local hospitals might be brought into the picture to assist with the teaching.

Other conferences for these high school teachers are being planned where they are needed.

—KATHLEEN M. LEAHY

NEWS

Highlights on Wartime Nursing

HAVE YOU REGISTERED?

By the middle of February only 50 percent of the graduate nurses in the United States had returned their registration cards in the 1943 National Inventory of nurses. A few states had completed from 70 to 80 percent of their cards. The returns from many other states were disappointingly low. This information is vitally important to nurses themselves, as well as to their country at war, since these data will be used as a basis of operation for a nursing supply unit now being set up in the War Manpower Commission. *The closing date for returns has been extended from March 1 to April 1.*

If you have not filled in your card form, do so at once and mail to your local or state nursing council headquarters.

If you have not received a card form, secure one from the secretary or chairman of your state nursing council for war service.

This is a chance for voluntary cooperation on the part of every nurse in the effort to determine and plan for wise use of national nursing resources. Do not fail to send in your card.

NURSING COUNCIL ACTIVITIES

The work of the Clearing Bureau of the Council will be continued with financial help from the Milbank Memorial Fund. To date 60,000 letters have been answered relative to the enrollment of students in nursing schools.

Almost \$85,000 has been contributed for nursing scholarships including the generous gift of \$50,000 from the American Legion Women's Auxiliary. This fund is

to be spent, not for tuition, but for necessary personal expenses of nursing students. Mrs. Charles Gilbert, chairman of the Auxiliary's National Defense Committee, will direct expenditure of the fund, with the Council's offices as headquarters.

Helen Schwarz has been released by the University of Cincinnati for two months to direct the Council's field service unit for assistance of schools of nursing in the acceleration of basic nursing education. Special funds for this purpose have been contributed by the Kellogg Foundation.

STUDENT ADMISSIONS BELOW GOAL

During the school year, June 1, 1942 to May 31, 1943, 49,169 students were admitted to the 1,300 state accredited schools of nursing according to a study just completed by the National League for Nursing Education. This is 89 percent of the quota (55,000) set for the year. A few states, Arkansas, Idaho, Iowa, New Mexico, North Carolina, Oklahoma, and West Virginia, exceeded their quota with enrollments of more than 100 percent of the goal for the state. Minnesota reported 100 percent, and 20 more states 90 to 98 percent of the quota reached. Only five states were 75 percent or under.

MAY CAMPAIGN

In May the Office of War Information will promote a special campaign for enrollment of student nurses. Department stores will take a leading part through newspaper advertising and window displays, and by maintaining information booths about nursing in the stores.

NEWS NOTES

RED CROSS NURSING SERVICE

"The fiscal year 1941-42 was one of intense activity for the entire Nursing Service" states the latest Annual Report of the American National Red Cross. These in brief are a few of the report's highlights as regards nursing:

During the year 19,628 nurses enrolled: First Reserve—13,792; Second Reserve—5,602; unclassified as to reserve—234. Assigned with the armed forces were 10,402. As of June 30, 1942, a total of 81,088 nurses had active status: First Reserve—32,193; Second Reserve—44,805; unclassified as to reserve—4,090.

In the Red Cross Home Nursing program 396,214 students received certificates, almost four times as many as in the previous year; 19,564 instructors taught one or more classes as against 2,525 the year before. The report states, "22 percent are carrying classes as part of their regular programs in public health nursing . . . in many instances at great personal sacrifice."

Through chapter public health nursing services, 778 nurses cared for 242,052 patients in 897,260 visits. Mention is made of special services established in communities where the need was very great.

The Volunteer Nurse's Aide Corps was greatly expanded during the fiscal year: 29,116 students enrolled and trained in 1,087 hospitals; 16,669 completed the course and served or are serving in 903 hospitals, 232 health and school departments, 83 visiting nurse associations, 106 industrial and other clinics, and in many blood donor centers.

Recruiting stations, numbering 370, are being set up in Red Cross chapters in the larger cities and towns of the United States, following the request of the Army that the Red Cross assume full responsibility for recruiting all Army nurses. Forty full-time recruitment secretaries are working in centers of large nurse population to acquaint all eligible nurses with the need for their services.

From Far and Near

• The following letter of February 24 from the director of the Bureau of Public Health Nursing in the Board of Health, Honolulu, Hawaii, contains information of interest to magazine readers:

It seems to us here in Hawaii that we have reached a stage where appeal through your pages for public health nurses is in order.

We are far from the source of supply for qualified public health nurses and our position in a vital war area makes it imperative that we keep the areas for civilian health needs covered by competent public health nurses. At the present time the Office of Civilian Defense is furnishing transportation (expense and arrangements) for qualified nurses to Hawaii and our restrictions regarding civil service and the three-year residence are removed. The initial salary is \$172.50 with an annual increase to \$217.50 in five years.

Would you bring these facts to the attention of your readers?

• Word has come from the Children's Bureau of the appointment of Ruth Taylor as director of the Nursing Unit of the Division of Health Services.

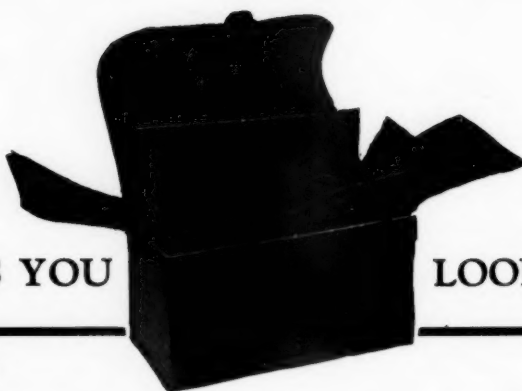
• Dr. George T. Palmer has joined the staff of the American Public Health Association as associate field director. He will travel extensively throughout the country advising on the improvement of administrative methods in state, city, and rural health departments.

• The revised "Nursing and How to Prepare for It" by the Nursing Information

(Continued on page A8)

The Stanley Seal

PROTECTS YOU



LOOK FOR IT!

● *Outwardly* bags may look alike—but there is only *one* genuine Stanley V.N. Bag and it bears the Stanley Quality Mark. You know there's much more to a bag than strikes the eye. In Stanley it's the *finest* topgrain cowhide—it's *hand-stitched* saddle craft—it's *special* waterproofing. In Stanley it's the amazing, new *Durit* lining, extremely light, yet rugged, washable, quick-drying, unaffected by oil, soap, alcohol. And, for your complete protection, *each Stanley V.N. Bag is dated!*

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Ask for new folder
on Stanley Bags,
Kits, Equipment,
white Durit Cloth
Aprons, etc.

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**STANLEY
SUPPLY CO.**
Nursing Supplies
121-B E. 24th St.
New York, N. Y.

News

(Continued from page 175)

Bureau is now ready, free upon request. It summarizes effectively and briefly military and civilian nursing needs for now and tomorrow, and tells how preparation may be secured.

What to Do in Gas Defense—A program for civilian protection against gas is being developed by the O.C.D. Physicians and non-medical personnel in all the regions are receiving special training, and local organization for action in case of an emergency is being perfected. Local agencies involved include among others the Emergency Medical Service which is responsible for the establishment and maintenance of gas cleansing stations (1 to every 50,000 population) and transportation, cleansing, and after-care of gas casualties; and the health department which analyses war gases, advises and acts in event of food and water supply contamination, and informs the public regarding the dangers and how to deal with them. Gas masks are now being distributed among the personnel of the protective services of the U. S. Citizens Defense Corps.

Save Fat—If every household collected half a pound of waste fat each month our wartime

needs would be fulfilled, states the U. S. Office of War Information. Fat is used to make the glycerine which makes the cordite which fires off the big guns. It has a host of other vital uses. Up to the present time, perhaps because of ignorance or lack of organization, only a sixth of what might be saved has actually been turned in to the authorized collection agents—the butchers. Housewives must redouble their efforts. They will be paid for waste fat at the rate of four cents a pound. Public health nurses are in a position to pass this word along.

Planned Parenthood in Wartime—Dr. Richard N. Pierson, president of the Planned Parenthood Federation of America, recently summed up 1942 accomplishments in planned parenthood as follows: The A.M.A. Council on Pharmacy and Chemistry has accepted the responsibility for testing and reporting on contraceptive products; five more state medical societies have recommended that private and public health physicians provide child spacing information, bringing the total to ten; three state health departments joined North Carolina, South Carolina, and Alabama in the list of states officially including child spacing in public health programs; the Division of Industrial Hygiene, U. S. Public Health Service, included in "Outline of an Indus-

PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

Trading in Educational Futures

THE PLACE of Nursing in Health Service" by Dr. Hugh Cabot, which appears in these pages, strikes a responsive chord in those of us who agree with the principle underlying his major premise that, in order to bring about the application of our enormously increased resources in preventive medicine and public health, we need a team of well-prepared public health personnel, an important member of which is the public health nurse. Dr. Cabot envisages her as a close associate of the doctor to whom the latter will delegate many of the responsibilities and duties which, speaking generally, we heretofore have believed belonged to medicine. Everybody knows, however, that under pioneer conditions and in unorganized communities whose health and medical resources are scant or non-existent, a public health nurse frequently functions beyond what is referred to as the legal line between nursing and medicine.

In order that "the health nurse" of the future may be qualified, Dr. Cabot suggests that "her preparation must be broader and deeper than what we ordinarily require for trained nurses." For many years, in fact since early in the twentieth century before the term public health nurse was in common use, the need for preparation—beyond hospital training—for nurses who worked in the homes, schools, and clinics—in other words, outside the hospital—was recognized. One of our earliest important studies, "Nursing and Nursing Education in the United States,"* was under-

taken because the public health nurse employers of that day felt that the graduates of the schools of nursing were not prepared for public health nursing. Consequently postgraduate courses in public health nursing, the first one of which had been established in 1910, continued to develop. At present there are 32 such university curricula approved by the National Organization for Public Health Nursing. In 1920 the National Organization formally undertook to approve these curricula, chiefly because of its interest in the development and maintenance of standards of public health nursing service. It realized that the first principle underlying the improvement of service is qualified personnel. Through the intervening years, the number of nurses who have met the recommended qualifications for public health nursing positions set up by the N.O.P.H.N. has increased steadily due to various factors, one of which has been the Social Security Act, provisions of which enabled many nurses to get needed preparation.

Since it is obvious that as schools of nursing go, so goes public health nursing, we as former products of these schools and as teachers, supervisors, and employers of future graduates—must be concerned with what is going on in them. Much progress has been made in basic

*Nursing and Nursing Education in the United States. Report of the Committee for the Study of Nursing Education, Josephine Goldmark, Secretary. The Macmillan Company, New York, 1923.

PUBLIC HEALTH NURSING

nursing education within the past twenty years. Publications of the National League of Nursing Education—such as "The Essentials of a Good School of Nursing" (now in a second edition), "The Nursing School Faculty," "A Study on the Use of the Graduate Nurse for Bedside Care in the Hospital," "A Curriculum Guide for Schools of Nursing" (second edition revised), and "Administrative Cost Analysis for Nursing Service and Nursing Education"—are all indicative of the progress which has been made. As the field of preventive medicine has expanded there has been a growing recognition of the importance of the health and social aspects in nursing and since 1937 this has been intensified by the emphasis given in "A Curriculum Guide for Schools of Nursing" to nursing and health service in the family. In fact, this enrichment of the basic curriculum has progressed to such a degree that there are today several university schools of nursing in the country which have as their objective so to prepare nurses that after graduation they are ready, without further preparation, to serve in any institution or agency in the community as a staff nurse.

Therefore, continuous study of the basic curriculum is imperative for public health nursing educators if they are to keep abreast of changes and trends. It is not possible to develop true postgraduate courses on a poor foundation in nursing education without strengthening that foundation, any more than it is possible to build a substantial house on top of weak underpinnings without adequate reinforcements. Institutions which permit a student with inadequate basic preparation to take postgraduate work are in reality adding a second handicap—albeit in the form of some label such as a certificate or degree denoting completion of certain academic requirements—to the

initial handicap of poor basic preparation.

Responsibility for the recruitment of nurses for public health nursing who will meet university standards of admission, and for analysis of the curriculum in terms of "The Public Health Nursing Curriculum Guide" and the needs created by the war are serious obligations of public health nursing educators today. Now more than ever clear thinking is needed. We should not permit old patterns to prevent our questioning current practice in our search for that which is fundamental.

With many of Dr. Cabot's ideas we are in agreement. We believe in the co-ordination of curricular offerings for the various public health workers because it is sound for these groups, the members of which are going to work together in the service agencies of the community, to begin to learn to do this by studying together the things they have in common. This has been done in the past and still continues in the universities which have schools of public health and which offer programs of study in public health nursing. It would be worthwhile to try to find out from graduates of these universities whether the plan has been successful so that as a result they do a better job by virtue of understanding and appreciating the role of the other members of "the health team."

Doubtless Dr. Cabot's suggestion that the education of the health nurse should lead to the degree of Bachelor of Medicine will cause considerable controversy. However, this matter of the terminology of the degree is important only insofar as it reflects the content of the curriculum to be followed. Dr. Cabot states that he lacks the knowledge to go into the matter of content but refers to the fact that the health nurse will require preparation in the field thought of as

EDUCATIONAL FUTURES

nursing today in addition to a broadening and deepening of much of the content in certain areas which is now offered in public health nursing curricula.

While some of our readers may disagree with his interpretation of the role of the hospital nurse because it implies that the amount of prevention of disease and promotion of health possible of accomplishment within hospital walls is so negligible that the knowledge and necessary skills in this field are not essential equipment for the nursing personnel, yet it merits consideration for reasons of efficiency and economy, both extremely important in war and postwar periods. The following questions occur to us as we read Dr. Cabot's paper. We would like expressions of opinion about them

and other suggestions from our readers.

1. Is it timely for those of us whose chief concern is nursing education to think through again whether the goal of nursing education should be to give the same basic preparation to all nurses?

2. Does the experience of the past ten years support this contention, or are contra-indications now apparent?

3. Are we, as a profession, capable of scrutinizing critically the contemporary picture of nursing education in relation to the present social order, and at the same time seeing it steadily and seeing it whole?

4. Is there anything we can do about this during the war? What do you think? Won't you please let us know?

—MARY C. CONNOR, SECRETARY
EDUCATION COMMITTEE

Public Health Nursing and the Red Cross

IN REPLY TO a letter from Dr. Thomas Parran, Surgeon General of the United States Public Health Service, expressing concern in regard to the campaign to recruit nurses for the military and its effect upon public health nursing agencies, teachers in schools of nursing, and supervisors in hospital nursing services, Mary Beard, director of the Nursing Service of the American Red Cross, writes a plain statement of Red Cross policy in this regard. This clears up certain misconceptions in relation to recruitment aims which have had rather wide circulation, and re-emphasizes with authority many of the convictions with regard to public health nursing in war-time which have been expressed in the pages of *PUBLIC HEALTH NURSING* in recent months. A copy of this letter has been sent to every health officer in the United States. The letter follows:

February 16, 1943

My dear Dr. Parran:

Your letter of February 15 expresses the concern which we are all feeling in regard to the campaign to recruit nurses for the military and its effect upon public health nursing groups, teachers in schools of nursing, and supervisors in hospital nursing services.

It has been our policy since our letter of July 17, 1940 to reclassify all new enrollments of public health nurses in a deferred reserve. No notification of these enrollments has been sent to Army or Navy Nurse Corps except in a very few instances when the nurse has specifically requested this after she has become enrolled. This same policy has been followed in the case of nurses engaged in essential positions in schools of nursing since February 1942. By far the larger group of public health nurses now in service with the armed forces had already enrolled prior to July 1940. In other words, before the present policy of deferment adopted at that time, their cards were already on file with the Army and Navy. A reclassification of Red Cross nursing reserves is now in progress. Under this reclassification the cards of all public health nurses

PUBLIC HEALTH NURSING

still on file with the Army and Navy will be recalled and these cards will be placed in the deferred file. Any Federal public health nurse indicating availability for military service on her annual questionnaire is referred to the director of her service and the Red Cross waits for authorization from her director before sending notification of availability to the Army or Navy.

A recent analysis of 15,000 nurses assigned to the armed forces shows:

- 68 percent were from Institutional Field
- 21 percent were from Private Duty
- 6 percent were from Public Health
- 4 percent were from Miscellaneous Field
- 1 percent were from Industry

The Public Health Reserve remains untouched, there being as of January 31, 1943 a total of 1,753 nurses in it.

The situation in regard to recruitment for the armed forces at present is as follows:

I. According to the Directive of December 2, 1942 at the command of General Somervell and signed by the Surgeon General of the Army and Colonel Rogers, Executive Officer of the Medical Corps, the Red Cross Nursing Service has been given full responsibility as the official recruiting agency for the Army Nurse Corps.

II. The new classification of our reserves is as follows:

- (a) War Reserve: Those nurses single or married, under 40, and available for military service immediately or within six months.
- (b) First Reserve: Single nurses under 40, eligible for military service but for legitimate reasons not available in the near future.
- (c) Second Reserve: Nurses not eligible for military service.

III. The Army Medical Corps has decided to appoint a special group of recruitment nurses. There are now 38 of these. On February 12 Miss Banfield, who is our Assistant Director of Nursing Service in Charge of Enrollment, went to Chicago in order to meet with the 38 Army officers who are assigned to field agencies of the Officers Procurement Service, so that they might together develop a thorough understanding of the method by which these newly-appointed Army recruitment nurses will work under the direction of the Red Cross.

IV. The Red Cross has added 32 nurse recruitment secretaries to its staff. You will see that this makes a formidable array of workers.

V. The Red Cross Chapters situated in cities having a population of 25,000 or over are adding their facilities, such as the assistance of lay peo-

ple and those trained in public information service, to the recruitment program. It is from these centers that the largest number of nurses must be recruited. In all of these communities there will be an intensive drive to get qualified nurses for the armed forces. No matter how carefully we try to safeguard against undue stimulus which will make public health nurses and teachers in schools of nursing uneasy and not sure that their duty is to stay at home, it will be an inevitable result of such an intensive campaign that many who ought not to leave will do so.

There seem to me to be two lines which should be followed to counteract the influence of such stimulated recruitment. One, and perhaps the most important, is the program of the newly formed National Nursing Supply Board of the War Manpower Commission. The other is the Red Cross effort to have the entire group of special nurse workers—the Army recruiting nurses and the Red Cross recruitment secretaries—understand thoroughly our conviction that there are many nurses who ought not to leave their present positions in order to do military nursing at this time.

Will you not give us your advice. If you believe that it would be helpful to bring a small group of health officers, teachers in schools of nursing, and nurses concerned in this recruitment plan together, will you not let me know and I shall try to arrange such a meeting.

We learned this week that Lt. Col. Florence Blanchfield is to be Superintendent of the Army Nurse Corps and that although she will not hold that position formally until June first, yet it has been announced that the temporary position which she is now holding is to become permanent on that date. Miss Blanchfield is, I believe, in complete sympathy with the point of view described above.

Inasmuch as so many years of my life have been spent in the interest of public health nursing, and because during the last war I was president of the National Organization for Public Health Nursing, and in that capacity, tried hard to keep public health nurses at home, my conviction that it is essential that public health nursing be not disrupted during a period of war is very strong. However, I agree with you that one cannot be the conscience for any other individual and that the urge which young nurses feel to join the Army or Navy Nurse Corps is a powerful incentive to action.

We shall be very grateful for your advice.

—MARY BEARD, DIRECTOR
NURSING SERVICE, AMERICAN RED CROSS

The Place of Nursing in Health Service

By HUGH CABOT, M.D.

ONE OF THE few benefits which results from war is that it puts a strain upon our physical, intellectual, and social resources and brings to the surface many unpalatable facts which might otherwise have been kept discreetly out of sight. Thus we have become acutely aware that the physical condition of a people is an enormous factor in their successful conduct of war. In this country we have been surprised and even shocked by the number of relatively young men who are rejected for military service. Among the various difficulties which have thus come to light has been malnutrition, not to stress defective teeth and other lamentable conditions which show defects in the health service which the population has received. The war has also drawn our attention to the change in the center of gravity of our thinking in regard to the health of our people, though this shift has been evident for a good many years, and we are beginning to appreciate that the goal is positive health rather than the maintenance of great repair shops and a tendency to look after people only when they have become ill.

Modern thinking regards health service as including not only the diagnosis and treatment of disease but the fullest application of our enormously increased resources in preventive medicine, including sound hygienic and nutritional habits. This shift in our thinking requires shift in our educational offerings and it is notorious that our educational planning, as a rule, follows rather slowly changes in social development. It is time that we

faced the requirements for the education of a balanced personnel for medical care, and extended and coordinated our educational offerings which have tended to develop in separate compartments such as medical and dental education, nursing education, sanitary and public health education, and the training of laboratory workers.

Slowly, and in spite of much resistance to change, we have grasped the fact that medical care, meaning chiefly the diagnosis and treatment of disease, has ceased to lie within the province of the individual physician and now requires for its effective performance a team of physicians in order that the general physician and the necessary specialists may work in close collaboration. The same teamwork will be required in the development of satisfactory personnel for health service as contrasted with looking after sick people. This team will require:

1. A sufficient supply of physicians, both general and special, including dentists.
2. Health nurses with a training broader and deeper than what we ordinarily think of as required for trained nurses.
3. Hospital nurses whose largest field will be in hospitals and dispensaries.
4. Practical nurses, being people with less prolonged and elaborate training who can yet do a great deal of the work, essential and time-consuming, now done by more highly-trained people.

Though it will obviously be impossible even to indicate how our educational offerings for such varied personnel should

be developed it will perhaps be worth while to indicate the relation of the various parts to the whole.

1. Physicians will obviously be the most highly-trained group and, in many respects, the pace-setters of the team. The rapidly developing aspects of modern science which are or may be applicable to the prevention and care of disease will certainly require of physicians a long, elaborate, and expensive education. This obviously cannot be considered here, though I am inclined to suggest that modern medical education has been thought to require so much scientific training that it has tended to neglect the very large social implications essential to the highest type of medical care. The modern physician is extraordinarily well trained in science but often sadly ignorant of the economic and social setting in which his work will have to be done if he is to occupy the most effective place in the team.

2. The health nurse. I have intentionally avoided the use of the common phrase "public health nurse" because I think it carries with it certain implications which tend to limit its greatest usefulness. In popular thinking the public health nurse is inevitably associated with the public health officer whose duties in the past have been considerably supervisory and administrative and who has dealt more with community problems than with individual fitness. As I see the future of the health nurse she should be the immediate associate of the physician insofar as he deals with positive health rather than with active disease. Part of the increased strain thrown upon physicians by the demands of modern science has been that science has placed at his disposal so many highly-technical procedures which he alone is competent to handle that it has made it increasingly more difficult for him to deal with the detailed and personal

problems of positive health in his desire to bring the possibilities of science to the care of disease. I am clearly of the opinion that a properly trained group of health nurses could not only relieve the physician of much detail work but greatly improve this work in many fields. The background of her education should be the ideal of positive health. She must know the principles of preventive medicine, of sanitation, of nutrition, and of health education. As she gains in practical experience she can be of immense value in preliminary sorting of medical problems, in personal education, and in supervision of health problems. I do not suggest that she will not also require education in the fields today thought of as nursing, but much of this work can I think better be done by another group and some time might be saved in the education which would be demanded of her.

Here, at once, we shall have to admit that much of the work which she will do is comprehended under the present legal definition of the "practice of medicine." As a matter of fact, our legal definitions which at present forbid women with a nurse's training from stepping over a legal line have resulted in much confusion and have in practice been frequently honored chiefly in the breach. The line is defined by law but defies practical application. In theory, nurses are supposed to act under the orders and supervision of physicians but in practice these orders must necessarily be very general and the supervision highly cursory. Moreover, the line is not, I think, in the public interest and tends to raise artificial barriers which obstruct sound health service. Thus, the industrial nurse, the public health nurse, the dispensary nurse will commonly in fact practice medicine, and strict enforcement of the law would simply cramp their good work. Now I do not mean to suggest that the practice of medicine should not

be carefully defined by law but I do mean to suggest that the law should no longer be allowed to handicap sound social progress. It is for this reason that it would seem to me very wise for us to indicate clearly that the health nurse shall be, in fact, a junior partner in many fields of health service.

In order to do this in orderly fashion I think we should be well advised to so plan her training that it would lead to the degree not of Doctor of Medicine, which today requires at least seven years of training, but to the degree of Bachelor of Medicine, a degree little used in this country but well suited to indicate her relation to the other members of the team. Her training will certainly require as much time and as much intellectual capacity as is now required for the Bachelor's degree in American institutions of higher learning. It may well be that it will require somewhat more time and thus come to rank above that of the Bachelor's in the more general fields. I do not at this time go into more details in regard to her training. This is partly because I lack the knowledge as well as the space. But the country is, on the whole, well supplied with experts who can work out a well-rounded educational offering which should, I think, come to include a very large group of people, chiefly women, who would immensely broaden and strengthen the whole structure of health service.

3. The hospital nurse. This trained group is today the largest in our educational program for the care of the sick. They are the people, who, after three years of hard and devoted service, have become the essential assistants and associates of the hospital physicians. Though I think many of the plans for their education still include too much of the remnants of the apprentice system they are an absolutely essential part of any orderly plan for health service. One of the most striking

characteristics of nursing as developed during the last 25 or 30 years has been the extent to which these women have more and more confined themselves to work in hospital environment and in the closest relation to the physicians doing scientific medical practice. Less and less have they been devoting their time to what used to be the general practice of nursing in which most of their work was done in the patient's home rather than in the hospital. This is but a natural corollary of the increasing use of hospitals both for diagnosis and treatment, and today whenever possible the intricacies of medical care are much better attended to in a hospital environment. More and more physicians will tend to group themselves not in medical office buildings but around hospitals, and the hospital nurses will work with them as essential associates. For this work the present three-year course leading to an R.N. may be regarded as satisfactory but it should be recognized that it is training a group of specialists concerned more with the problems of diagnosis and treatment than with the problems of positive health and the prevention of disease. This tendency to specialize does not seem to me as objectionable if it is recognized and treated as such.

4. The practical nurse. Finally, we come to the junior partner in this health service team and it seems to me that a considerably further development of nurses with much less technical training is of first-class importance in producing a rounded whole. We have, I think, not only neglected to train these people but we have made their position difficult by failing to recognize their strategic importance. The very phrase "practical nurse" chiefly calls to mind helpful women of uncertain age whose training has been almost wholly of an apprentice character, who are shockingly unfamiliar

PUBLIC HEALTH NURSING

with the jargon of modern medicine. They are nonetheless often surprisingly capable of making sick people comfortable and fill many an aching void. I think the training of such a group should be regularized and dignified far beyond anything which has been done on a large scale in this country. They might easily relieve the present hospital nurse of much apprentice work which is unnecessary to the hospital nurse's training and yet entirely basic in the orderly conduct of a modern hospital. These "practical nurses" should probably be trained at least a year and a half under hospital discipline but they will need much less fundamental education, particularly in the fields of applied science. As a matter of fact, such an educational offering would add much to the richness of the formal education of almost any woman in the modern world.

I HAVE thus very briefly and inadequately sketched the training of some of the more necessary members of the health

service team. I want particularly to stress the importance of the group that I have called health nurses. Without some such broadening of the field of nursing and without a very large number of women with a training somewhat of this type I do not think that we shall be able to build up in this country a health service offering which will utilize to the fullest extent the ever-increasing benefits which science has put at our disposal. Hand in hand with the broadening of our health service team must go the education of the whole community to look upon positive health as the goal of civilization and to regard the diagnosis and treatment of disease as an unfortunate necessity which our lack of understanding of our environment still requires. It is perfectly certain that a stable civilization which recognizes the health of the people as a primary necessity will desire to put the possibilities of modern medicine much more certainly at the disposal of the whole people.

Comments on Dr. Cabot's Article

DR. CABOT has pointed much of the thinking of progressive nurse educators in his provocative article, "The Place of Nursing in Health Service," while simultaneously touching the most sensitive and vulnerable spots in medical as well as nursing education. If the modern physician is often "lamentably ignorant of the economic and social setting in which his work will have to be done" how much more so is the nurse, trained only to perform specific techniques within the confines of the four walls of the hospital. Careful scrutiny of present nursing practices will disclose the fact that many

of the activities now carried out by nurses can very well be performed by trained auxiliary workers, ("practical nurses," Red Cross Volunteer Nurse's Aides and Ward Aides) and I commend the author for his fine understanding of the functions of this needed group and his intelligent suggestions for regularizing and dignifying the training of such a group. All of us who are "practical minded" will like his remark that "such an educational offering would add much to the richness of the formal education of almost any woman in the modern world."

Although I am in complete accord with

COMMENTS ON DR. CABOT'S ARTICLE

the philosophy expressed in this article and the kind of preparation Dr. Cabot proposes for the group of nurses which he calls "health nurses," I take issue with his suggestion that this richer preparation be limited to one group of nurses and that for hospital nurses ("who are concerned more with the problems of diagnosis and treatment than with the problems of positive health and the prevention of disease") the present three-year course may be sufficient. Regardless of the length of time it takes and what has been the preparation of the nurse in the past, somehow through more intelligent curriculum building, we must find a way to prepare all nurses for the job of "health nursing." *Every nurse, though she practice her profession in the hospital, home or community must know, be able to, and daily apply the "principles of preventive medicine, of sanitation, of nutrition and of health education."*

If this additional preparation in the biological, social and medical sciences is on a college level and requires more class, ward and field experience than can be given in a three or four year program, it will still be *nursing content* and will lead to the degree of Bachelor of Science in Nursing or perhaps one day when we are stronger as a profession, to the degree of *Bachelor of Nursing*. The degree is important only insofar as it helps us to raise the level of nursing practices and gives to the individual a better preparation for the work she has chosen to do.

Dr. Cabot's article is rich in suggestion and stimulation for those of us immersed in the sea of "acceleration." Let us remember that acceleration means enrichment and expansion as well as "speeding up" and that nurses tend to practice on graduation what they learned in their school program. In the words of Professor William Heard Kilpatrick writing in

the March issue of the Association of American Colleges Bulletin:

"We learn what we live, only what we live and all that we live; we learn it as we accept it to live and in the degree that we so accept it."

—LULU K. WOLF, R.N.

PROFESSOR OF NURSING EDUCATION
VANDERBILT UNIVERSITY, NASHVILLE, TENN.

DR. CABOT's picture of a team of health workers in which medicine and nursing serve side by side, no longer only for the care and cure of the sick, but for the promotion of health and the prevention of disease, makes stirring reading. Somewhat rudely awakened from our national dream of progress in health education by the draft rejection figures for 1942, strangely similar to those of 1917, we are forced to confess that practice still lags behind scientific advances in this field as in others. The realization is not heartening, for some of us have assumed that the discoveries which make preventive medicine possible have been so well assimilated by our population that the results are foregone conclusions.

Forced, then, to think in terms of altering the preparation of workers in the field of health to meet these changing needs, we are stimulated by the vision and challenge of a physician who sees in the nurse as helpful a colleague in health service as she has been for years in care of the sick.

The proposal for teamwork is truly heartening, and recognition of the fact that the basic nursing education most frequently available today provides for hospital teamwork but not for such association in the health services will be welcomed among many of us engaged in public health nursing. During the last twenty years a handful of universities have endeavored to prepare the type of person described by Dr. Cabot. The results,

PUBLIC HEALTH NURSING

while limited in quantity, have been encouraging in quality. Yet even these few progressive schools have not wholly solved the problem. Each has made its contribution but the ideal pattern is yet to emerge.

The long association of nursing education with direct hospital service, valuable as it is for clinical experience, has exercised direct restraint upon preparation for new fields of service made at the cost of decreased student nursing care of patients. Few schools have had sufficient financial independence to explore the educational opportunities suggested by Dr. Cabot. If, as the author has suggested elsewhere, federal funds can be made available for widespread nursing education for health services, there is readiness to attack the matter on a broad base and produce not the relatively few health nurses now available but the sizeable quantity accepted as necessary. The preparation in the basic curriculum of an increased number of nurses for field health service will also free the graduate programs for the development of advanced work already recognized as urgently necessary in public health nursing.

The suggestion that medical education likewise may think in terms of its new responsibilities in the team outlined presupposes cooperation in preparation as well as in community service later. Here, I believe, lies a long needed relationship for both professions.

Dr. Cabot suggests that a degree, new for nurses but long in existence for medicine, might be used to indicate the relationship of the health nurse in the proposed team—the Bachelor of Medicine. While appreciating the close association thus indicated, I would prefer to see an increase in the use of the Bachelor of Nursing degree. I thoroughly believe that

this nurse needs preparation leading to a baccalaureate degree, but consider an award which indicates her chosen profession more suitable than one in another profession, however closely related.

Of the preparation of the hospital nurse, I am not qualified to speak. It seems to me, however, that just as the health nurse needs background and experience in the care of the sick, although her major is health promotion, so the hospital nurse, concerned primarily with the diagnosis and treatment of disease in an institution, will also need some understanding of the community where health education goes forward. The recognition of the existing need for so-called practical nurses and the development of sound preparation for these workers is essential. No one active in public health nursing today doubts this. In household after household members of this group, to use Dr. Cabot's phrase, "make sick people comfortable." We need them as members of the team rather than as unacknowledged associates. Their presence on a basis of cooperative effort will certainly strengthen the contribution of the other workers, and be of direct value to patients.

As a public health nurse I am challenged by Dr. Cabot's proposals. His health service team, in which the health nurse is called upon to play so vital a part, accepts the goal which our predecessors in visiting nursing envisioned but could not live to realize—the acceptance by each individual in the community of positive health as the goal of our civilization with the consequent readiness to work individually and collectively for that goal.

—RUTH W. HUBBARD, R.N.

GENERAL DIRECTOR
VISITING NURSE SOCIETY OF PHILADELPHIA



Nurse-midwife demonstrates to colored midwives principles involved in delivery



Medical service is complemented by nurse-midwife, who examines return patients

Nurse-Midwives Serve a Rural County

By ELIZABETH R. FERGUSON, R.N.

THE PROBLEM of improving maternity and infant care in rural areas among families with markedly restricted incomes, with no local hospital and insufficient medical services available, presents unusual difficulties. This is especially true when a large proportion of the population is made up of Negroes who are generally satisfied with health conditions as they find them and often look with placid resignation upon the loss of a mother in childbearing or the death of her baby shortly after birth.

Charles County in Maryland was such an area and for this reason was selected for study. The object of the study was to learn what could be done for mothers and children of very limited means, with the added help of a nurse-midwife. The study included 879 women registered at the prenatal clinics during a five-year period.

This county is in a rural section of southern Maryland. It has an area of 464 square miles. The principal in-

dustries are tobacco raising, fishing, oystering and farming. The population in 1936 was approximately 16,000; 8,500 white and 7,500 Negro. There was no hospital. Baltimore is 65 to 90 miles away, depending upon the point of starting from the county. A hospital in Washington, 35 to 60 miles distant, was occasionally used for colored patients.

There were eight physicians, one-half of them in the county seat. One of the largest areas in the county had no resident physician. The doctors generally were willing to go to an indigent woman in difficult childbirth but were rarely asked to examine such a patient before delivery, still less to provide prenatal care. They welcomed any assistance that could be given to this group of women who were generally unable to pay for even the emergency services of physicians. Obstetrical patients with small means depended upon the elderly, untrained, often kind-hearted and conscientious midwives who despite their superstitions and ignorance

PUBLIC HEALTH NURSING

did the best they could for their patients. There were over a score of these midwives, nearly all Negroes, practicing in the county. They were fairly well distributed and delivered approximately 300 babies yearly. A majority of their patients were colored.

It was obviously impossible and not desirable for the one nurse-midwife to take over the work of the licensed midwives and at the same time give adequate care to her patients in a scattered rural area. It was therefore deemed advisable for the nurse-midwife to spend most of her time in teaching and supervising the licensed midwives so as to improve the quality of care that they were able to offer their patients. In due course the aged and unfit were eliminated and friendly assistance and training were given to a dozen licensed midwives who remained active. These midwives were instructed singly and in groups by the nurse-midwife and were helped by her in delivery of the midwives' patients in their humble homes. For the most part this help was gratefully received and the teaching followed. The nurse-midwife became their friend and counsellor and in abnormal cases was instrumental in obtaining the assistance either of a physician or hospital. They were easily brought to appreciate the value of the prenatal examination of their patients and almost at once referred them to the prenatal clinics. They soon refused to accept cases for delivery who had not had a prenatal examination at a clinic. During the period studied, the midwives of the county entered into the altered maternity and child health program with interest, and developed a sense of renewed responsibility for the welfare of the mothers and babies under their care.

Early in the service the nurse-midwife established six prenatal clinics in convenient places. At the prenatal clinics the history of the patient was taken by the

nurse-midwife and the examination conducted by a local physician interested in obstetrics. On return visits patients were examined by the nurse-midwife. An obstetrical consultant, a member of the obstetrical staff of Johns Hopkins Hospital, visited the county monthly and reviewed abnormal cases selected from the clinic group and from the nurse-midwife's case load. He was also able to see a number of private patients for physicians. This consulting service was extremely valuable both in teaching and for the feeling of security it gave the clinic physician and nurse-midwife. Recommendations for hospitalization were made on the consultant's findings. The Johns Hopkins Hospital accepted all cases recommended. It was rarely necessary for the patient to be admitted on an emergency basis. Telephone communication with the consultant between his monthly visits was extremely helpful in securing advice as to the management of a problem case. The nurse-midwife was given simple medical standing orders prepared by the consultant and approved by the practicing physicians of the county.

BIRTHS AND CLINIC ATTENDANCE

The number of births in the county during the period studied, as well as the number and percentage of expectant mothers attending the prenatal clinics is indicated in Table I.

It will be noted that the majority of the births in the county were Negro and that a large percentage of the expectant Negro women in the county were examined at the prenatal clinics. Important to bear in mind is the fact that except through the prenatal clinics, these women would have had no examination before delivery. The majority of white patients went to their physicians for some prenatal care.

The time of first examination varied

NURSE-MIDWIVES

Nurse-midwife gives confidence and valuable instruction as she assists Negro midwife at delivery



little in the five-year period. In 1936, 22 percent of the patients were seen before the sixth month; in 1937, 30 percent; in 1938, 22 percent; in 1939, 28 percent; in 1940, 26 percent. An average of 25 percent of the patients were seen before the sixth month. An average of 49 percent were seen by the seventh month.

CLINIC FINDINGS

Serological tests for syphilis were taken on all patients. Among the colored group

20 percent showed positive reactions. None of the white women reacted positively. Treatment was not available for more than an estimated 50 percent of the patients, due to lack of transportation facilities.

Forty-one patients, or 5 percent, were found in the clinics to have abnormal pelves. These patients were all rechecked by the consultant. Of these, 13 were hospitalized at his request. Five of them had spontaneous deliveries, four were de-

TABLE I
BIRTHS IN CHARLES COUNTY, MARYLAND, AND EXPECTANT MOTHERS ATTENDING
PRENATAL CLINICS

Year	Number of births		Number attending prenatal clinics		Rate per 100 births attending prenatal clinics	
	White	Negro	White	Negro	White	Negro
1936	204	235	10	71	5	30
1937	203	231	22	142	11	62
1938	198	244	31	151	16	62
1939	219	252	26	226	12	90
1940	182	219	14	186	8	85
Total	1006	1181	103	776	10	66

PUBLIC HEALTH NURSING

TABLE II
TYPE OF ATTENDANT AT DELIVERY

	Doctor	Midwives and nurse-midwife	Hospitals	No attendant	No knowledge as to attendant
1936	1	72	7	1	0
1937	1	151	10	0	2
1938	3	153	19	0	7
1939	15	198	34	4	1
1940	1	171	26	2	0
Total	21	745	96	7	10

livered by forceps, one by podalic version and three through Caesarean section.

Toxemia (two blood pressure readings of more than 140/90) in the five-year period occurred in 66 women, or eight percent. Forty-two of these were delivered at home, 24 in hospitals. In the latter group the termination of the pregnancy was as follows: 1 therapeutic abortion (B.P. 232/150, two or three months pregnant), seventeen spontaneous deliveries, one spontaneous delivery of a six-months premature, four Caesarean sections (two of these women also had contracted pelvis), one forceps delivery.

Patients with symptoms of toxemia whenever possible were seen by the consultant. Advice given the toxemia patient in clinic was: bed rest, saline cathartic, light diet, and restriction of salt. These women were followed closely in the home by the nurse-midwife. Patients who did not improve with this regime were usually hospitalized. The delivery of

these women, when it occurred in the home was supervised by the nurse-midwife. All patients with symptoms of toxemia recovered.

DELIVERY RECORD

A record of the delivery of the 879 women attending prenatal clinics is shown in Tables II and III. It will be noted that approximately 11 percent of deliveries were in hospitals, and that 1.6 percent required operative delivery. Following operative delivery evidence of birth injury was manifested by one case of Erb's palsy (high forceps delivery in hospital) and one case of facial paralysis (mid-forceps delivery in home). Both infants recovered normal function. There was one maternal death in the five-year period, a multipara who, in a hospital, died of rupture of the uterus following an attempted version.

Stillbirths

In the series of cases studied there were

TABLE III
TYPE OF DELIVERY

	Spontaneous	Caesarean section	Other operative	Unknown
1936	77	0	4	0
1937	160	2	0	2
1938	175	0	1	6
1939	243	2	2	5
1940	191	1	2	6
Total	846	5	9	19

NURSE-MIDWIVES

26 infants stillborn, a rate of 29 per 1,000 live births. In Charles County the stillbirths are usually over 50 per 1,000 live births, that of the Negro group over 70. It was not practicable to obtain complete information as to the cause of the stillbirth in each case. In two instances it was toxemia in mother; in one instance, twin with prolapsed cord; in one instance, a breech with delayed after-coming head; in two instances, version and breech extraction. Other causes associated with stillbirths were not ascertained. Serological test for syphilis in all mothers of stillborn infants showed five mothers positive, four doubtful, and seventeen negative. All stillbirths occurred among the Negro women.

Neonatal Deaths

In the series of cases studied there were 22 infants born alive who died in the first month of life. This represents 28 neonatal deaths per 1,000 live births. In Charles County as a whole the neonatal rate varied from 30 to 46 in the period studied.

The following conditions were associated with these deaths: cerebral hemorrhage, 1; prematurity, 7; syphilis in mother, 5; postpartum psychosis in mother, 1; toxemia of mother, 3; no cause assigned, 5.

SUMMARY AND CONCLUSIONS

A maternity program was carried on in Charles County, Maryland, by nurse-midwives for a five-year period during which a careful survey of the health problems and needs of the county was made. Clinics were organized, midwives were taught and supervised on deliveries, home visits were made to prenatals, post-natals and infants, doctors were assisted with most of their complicated home deliveries.

1. Because of inability to place enough nurse-midwives in the county to handle

the deliveries of the poorer patients, and the difficulty of placing highly-trained people in an entirely rural county unit set-up with any expectation of their staying long, the local midwives were taught over a period of four years. This met with the entire approval of the medical society who felt as a group that the midwife was a social necessity in this area. Almost all of the patients were sent in to the clinics by the midwives. Rarely were promotion visits made by the nurse-midwife, thus saving a great deal of time and effort.

2. The clinics served the colored population to an extent that brought some 66 percent of these expectant mothers under care. This group was unable to secure other types of maternity and infant service.

3. Of 879 patients examined in the clinics there was only one maternal death.

4. Of the deliveries recorded 98 percent were spontaneous.

5. In this area where hospitalization was arranged only when it was impossible or unsafe to keep the patient at home, 11 percent of the total group was delivered in hospitals. Of these, 93 percent were sent in by the nurse-midwife or obstetrical consultant; 7 percent arranged their own hospitalization.

6. About one fourth, 27 percent, of the clinic patients were primigravidae. This group of mothers with first babies thus got a good start and an understanding of what adequate care means in subsequent deliveries.

7. There was a very low incidence of operative deliveries—1.6 percent.

8. Of the 66 toxemic patients, 24 were hospitalized. Among this group of 24, there were four Caesarean sections.

9. There were 26 stillborn infants 3 percent of the total liveborn group. Syphilis and toxemia account for some of the stillbirths.

PUBLIC HEALTH NURSING

10. The neonatal deaths were 22—2.5 percent of total live births for the five-year period. The low rate may be accounted for by intensive follow-up nursing work and by the efforts on the part of the mothers to use nursing service to help in keeping babies well. In most instances the nurse was called when the first sign of illness or loss of weight was noticed in contrast to the nonclinic group which called the doctor quite late.

We have concluded that low-income maternity patients in a rural area where medical facilities are limited can be cared for safely at home by lay midwives when cases are selected and their work is supervised. This has proved to be an economical service. Although in the year following the study we were unable

to supply this county with a nurse-midwife, there has been no change in the clinic attendance or the maternal death rate.

It must be understood that this program of providing maternity care through midwives is not considered ideal. Delivery in a hospital is to be preferred if the facilities in the hospital are adequate. Otherwise it may be more dangerous to both mother and child than when the birth takes place in a poor home. This study in Charles County, Maryland, does indicate that women can be given fairly safe care by licensed midwives if they are interested, instructed, and supervised by a competent nurse-midwife.

The pictures are by courtesy of the U. S. Children's Bureau.

NURSE PLACEMENT SERVICE

N.P.S. announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom consent to publish these has been secured in each case from both nurse and employer.

PLACEMENTS

*Winifred Virginia Cushing, supervisor, Tulsa County Public Health Association, Tulsa, Okla.

*Lela Mae Carver, public health nurse, Carter Coal Company, Coalwood, W. Va.

Mrs. Victoria Casolare, industrial nurse, Kroll Baby Carriage Company, Chicago, Ill.

Mrs. Norma D. McCaffrey, industrial

nurse, Container Corporation of America, Chicago Ill.

Grace Harriet Holm, staff nurse, Lorain County District Health Department, Oberlin, Ohio

ASSISTED PLACEMENTS

*Portia G. Irick, nursing consultant, American Red Cross, St. Louis, Mo.

*Margaret Faye Allen, assistant supervisor in public health nursing, University of California, Los Angeles, Calif.

*Mrs. Charlotte Stanley, staff nurse, Mt. Vernon Visiting Nurse Association, Mt. Vernon, N. Y.

*The N.O.P.H.N. files show that this nurse is a 1942 member.

A Definition

THE REQUEST that something be done about the definition of the terms "specialized and generalized nursing" came as a result of Naomi Deutsch's experience in collecting data for her paper on "Evaluation of the Various Types of Supervised Field Practice Offered to Students Enrolled in Public Health Nursing Courses," which she gave at the joint meeting of the state directors and collegiate council in Atlantic City in October 1941. She found the terms so loosely used, especially "generalized nursing," that it was very difficult to determine what types of experience students were really receiving.

The N.O.P.H.N. has used the terms in relation to administration. The following statement appears (page 146) in the *Survey of Public Health Nursing* (published by The Commonwealth Fund, New York, 1934).

A generalized nursing program is one which consists of several types of nursing service administered by one agency, each nurse giving all these types of service to the families under her care. Agencies sometimes administer several types of nursing service, each of which is represented in the field by a special nurse or group of nurses. This kind of program is here designated as specialized. In addition, there is sometimes found the completely specialized program, which consists of a single type of nursing service administered by an agency.

Much of the confusion seems to be caused by the variation in types of service which are included in the programs. With this in mind, the committee wishes to add to the statement of the N.O.P.H.N. and to submit the following definitions for consideration.

Report of the committee appointed at the meeting of the state directors of public health nursing at Atlantic City, October 13, 1941, for the purpose of defining the terms "Specialized Nursing" and "Generalized Nursing."

Specialized Nursing Program

A specialized nursing program is one which consists of a single type of nursing service administered by an agency or one which includes several types of nursing service, each of which is represented in the field by a special nurse or group of nurses.

Generalized Nursing Program

A generalized nursing program is one which consists of several types of nursing service administered by one agency, each nurse giving all these types of service to the families under her care.

A complete generalized public health nursing service should include formulated programs in all the public health nursing services contained in the "Tabulation of Health Department Services" which is approved by the State and Territorial Health Officers, U. S. Public Health Service, and U. S. Children's Bureau. These services are communicable disease, venereal disease, tuberculosis, antepartum, delivery, postpartum, infant, preschool, school, and adult hygiene, morbidity service, and crippled children service.

When all these services are not included, an agency should so state in explaining its program, for example: "Complete generalized with the exception of delivery service," or "Generalized program including morbidity, antepartum, delivery, postpartum, infant, preschool, adult hygiene, and communicable disease services."

There are many ramifications to the problem and it does not seem possible that all of these can be encompassed by any definition of the terms. The definitions do not indicate possible limitations in any of the services of a program nor

(Continued on page A11)

The two articles "Communicable Disease in Wartime" by Margaret G. Arnstein, R.N., and "Emergency Public Health Nursing in Communicable Diseases" by Joseph I. Linde, M.D., were prepared under the auspices of the Committee on Nursing Administration. The first emphasizes the need to be ready to meet the unpredictable course which certain communicable diseases may take under wartime conditions; the second, what constitute minimum public health nursing services in relation to each of several communicable diseases which may occur. The articles are not intended to be all-inclusive and public health nurses are urged to review their knowledge of communicable disease control in such standard texts as suggested at the end of Dr. Linde's summary—particularly the "control points" of the separate diseases. But when the need is immediate and personnel is limited, this brief review may be suggestive in administrative decisions in regard to distribution of personnel and services.

Communicable Disease in Wartime

BY MARGARET G. ARNSTEIN, R.N.

THE WAGING of war has always been attended by an increase in the prevalence of disease. In consequence, it has been fully expected that once again the conditions of war would bring us epidemics. Anyone who reads any of the public health journals or even the daily newspapers has noted innumerable articles about the expected increase in communicable diseases, and recently surprise has been voiced that this expected increase has not yet occurred, and that there has been no pandemic of any disease. It is the purpose of this article to examine some of the facts back of these statements as they relate to public health nursing.

It would be difficult and confusing to attempt to describe the situation in relation to all the important communicable diseases as the problems in connection with the various types are so totally different. In fact it is dangerous and misleading to talk in general terms of an increase or lack of increase of communicable disease without stating what diseases are under discussion. To be sure, the incidence of certain diseases has increased since the beginning of the war. Certain

others are being experienced for the first time by residents of this country, now that large numbers of the armed forces are stationed in the Far East, and thus exposed for the first time to some of the tropical diseases. In spite of all precautions these may be introduced into the United States by returning members of the armed forces. However, physicians are preparing themselves so that they will be better able to diagnose and treat these diseases should they encounter them. Nurses too must be ready to learn the nursing aspects involved. The tropical diseases, those transmitted through the intestinal tract, and the genito-infectious diseases have already been discussed in the magazine. Therefore, at this time discussion will be limited to common respiratory-spread diseases of the temperate zone.

The fear of widespread epidemics was based on the experience of previous wars. A few examples of past upsurgings of communicable diseases in the general population, not in the armies, are sufficient to remind us of the potential danger of communicable diseases in wartime against which we must be ever vigilant.

COMMUNICABLE DISEASE IN WARTIME

TYPHUS fever, smallpox, typhoid fever, and dysentery apparently occurred in epidemic proportions and can be recognized as disease entities as early as the sixteenth century and even earlier. Again in the first world war smallpox flared up in all parts of the world. In the years immediately following there were severe epidemics in Austria-Hungary, Italy, and a greatly increased incidence in England, Wales, and the United States. Clara Cuncell in her excellent historical review of the "occurrence of communicable diseases in relation to war" states that:

Armies and civilians suffered greatly from smallpox during the American Civil War (1861-65). At the time of the Franco-Prussian War it was very prevalent among the French, but few of whom had been vaccinated, although there was little among the better protected German Army. War prisoners carried the epidemic to Germany where a large part of the population was not vaccinated, and no nineteenth century epidemic could compare in extent and virulence with that which raged after 1870 throughout Germany, Belgium, Switzerland, the Netherlands, Austria, England. . . .

Cerebrospinal meningitis was widespread and fatal, not only in the war zone but also in other parts of the world. Figures for Austria show 3,226 cases with 1,601 deaths in the 4 years 1915-18, inclusive. In the last 6 months of 1915 alone there were 222 cases with 107 deaths. In England this disease maintained a prevalence hitherto unequalled. In the wartime epidemic period of 1914-18 there were 6,450 cases reported among civilians in England and Wales and 4,238 cases among military personnel.

Outbreaks of encephalitis lethargica were noted among British and French civil and military populations in 1917-18. This disease swept various European countries at different times and attained its highest incidence in and after 1920. In the United States and most of Europe a decline was evident after 1924.

Association with influenza has been noted in the occurrence of cerebrospinal meningitis, encephalitis lethargica, and other epidemic diseases of the central nervous system. At the end of the war of 1914-18 influenza completely overshadowed all other diseases in importance, and in extent and virulence was comparable to the plagues of early history. The occurrence of the

pandemic of 1918-19 may have been coincidental with, but was certainly exacerbated by, the conditions of wartime and its after effects.¹

Why there has not been any such increase in this war is not entirely understood. Certainly conditions in the bomb shelters in London in 1940-41 were ideal for the spread of influenza, pneumonia, or meningitis and yet meningitis was the only disease that showed any marked increase and even that did not reach epidemic proportions.³ However, Major Greenwood² reports from his experience with animal colonies that some small unknown factor may upset the balance under these conditions. We may still have severe epidemics and we must be prepared for this possibility.

THE respiratory diseases may well be divided into those for which there is an effective active immunizing agent, and those for which there is none. Smallpox, of course, falls into the first group, and every man and woman in the armed forces is immunized against this as well as against several other diseases. There is a greatly increased danger to civilian populations, too, from this disease as well as from diphtheria, and probably one of the public health nurse's chief jobs at the present time in relation to communicable disease control is to assist in increasing the number of civilians immunized against these diseases. The movement of people from one area to another always increases the possibility of spread of communicable disease, for "non-immunes" move to communities where the disease is not prevalent but nevertheless may exist in carrier form, and carriers may move into new groups of susceptibles. Therefore populations which have been comparatively free from these communicable diseases may suffer severe outbreaks unless a high level of immunization is maintained at all times.

PUBLIC HEALTH NURSING

Halifax in the winter 1940-41 had such an outbreak. During that winter there were 588 cases of diphtheria among the civilian population and 303 in the armed forces, with 72 deaths, mainly in the younger age groups. At the same time there were 576 cases of scarlet fever and 97 cases of meningitis. As can be imagined this more than taxed the medical and nursing resources of that community. The diphtheria cases were severe and there were many complications of all kinds, severe paralysis, cardiac involvements, tracheotomy cases. A public health nurse unused to seeing serious cases of this type would do well to read Dr. Allan Morton's¹ account of this epidemic. Reading a first-hand account of so recent an outbreak would certainly add increased vigor to her educational efforts in behalf of immunization.

We have no satisfactory active immunization against influenza, pneumonia, meningitis, measles, mumps, or the other so-called children's diseases, and the protection against scarlet fever has not to date been considered suitable for general use in civilian populations. Therefore, there is little to be done to prevent spread of these diseases, except, of course, for milk-borne scarlet fever, and all public health nurses can assist in promoting the use of pasteurized milk to prevent this type of epidemic. The only thing that can be done is to give the best possible care to persons suffering from these diseases. This involves knowing the most recent medical and nursing procedures and understanding their relative importance. In epidemic times one must usually confine care and instruction to the most vital points in order to save time and energy. In order to do this, most of us need to review the important points in connection with the control and care of each disease, and also constantly keep up

to date with new developments by reading medical and nursing periodicals.

A large epidemic can be more devastating than any form of enemy attack and the staffs of professional nursing agencies need to be supplemented by every available auxiliary worker in the community. The aim of the Red Cross to have at least one person in each home trained in home nursing is an important step not only in improving the care of the sick at any time but for providing valuable assistance in case of an epidemic.

Communities are now preparing for just such emergencies in the same way that they are preparing for enemy action. Inactive nurses and nurse's aides can be given instruction by public health nurses and can practice under their guidance and supervision so that they will be prepared to give safe and efficient care to persons sick at home.

One of the most difficult things to do is to be prepared for something that *may* happen some time in the future. Preparation for a possible epidemic requires keeping abreast of new discoveries about the communicable diseases, reviewing new symptoms and treatments both by reading and observation, and keeping this reference material available for quick but essential last minute review if an epidemic of one of the diseases actually occurs. Plans for the organization of community resources to meet such a crisis should be made in advance.

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- ³"The Winter Epidemics" (editorial). *British Medical Journal*, May 3, 1941, p. 673.
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Emergency Public Health Nursing in Communicable Diseases

By JOSEPH I. LINDE, M.D.

THE PUBLIC health nurse plays an important role in communicable disease. Her duties in this sphere involve: (1) nursing care (2) supervision of isolation and quarantine (3) assisting in epidemiological investigation and control measures and (4) health education regarding prophylaxis, nursing care, and control measures. During a time of national emergency, with the resultant migration of population, crowding, and unhygienic conditions, the duties of the public health nurse are increased. The fact that some agencies are already short of staff and at the same time trying to cope with additional work has brought to immediate attention the problem of reducing to a minimum the public health nursing services required for communicable diseases.

As stated by Miss Arnstein in the preceding article (p. 194) study of the course of a disease and its critical points must stress the most up-to-date theories on transmission and treatment. All are essential in setting minimum standards.

This article reviews in brief the important points which determine the objectives of public health nursing and the suggestions outlined as to the minimum visits required in relation to some of the more common diseases and a few others which may be expected to occur under certain conditions in wartime. Such an outline must be flexible, with each patient's individual requirements evaluated to determine the number of nursing visits necessary. Nevertheless, these



Metropolitan Life Insurance Company

The public health nurse watches her patient for the critical periods in the course of a communicable disease

standards are considered minimum according to the public health objectives enumerated in this article.

If possible, nursing visits should be timed to coincide with these critical points. For example, in case of scarlet fever it is important to visit early to set up isolation for the protection of others. It is important to visit at the end of the second week to check up on possible complications. If only two visits can be made to persons with scarlet fever, it would be desirable to visit at these two times, rather than at any other. The nurse should remember these points in planning her schedule.

PUBLIC HEALTH NURSING

What the Public Health Nurse Should Know About:

Public Health Nursing Objectives

Minimum Visits Required

CHICKENPOX

Usually a mild disease. Complications rare. Control impractical. May be confused with smallpox.

Differential diagnosis

1. Very slight prodromal symptoms in chickenpox, more severe in smallpox.

2. Lesions deeper seated in smallpox than in chickenpox.

3. Lesions begin on trunk and scalp spreading to face and extremities in chickenpox; begin on face and arms spreading to trunk and scalp in smallpox.

Only nursing care when needed.

No visits unless for nursing care.

MUMPS

Usually a mild disease. More dangerous after puberty since it may produce sterility through gonadal involvement.

Complications may be severe, involving gonads, pancreas, or brain.

Control impractical.

May be confused with cervical adenitis.

Differential diagnosis

In mumps swelling is "better seen than felt."

Mumps swelling is diffuse, boggy, extending behind, under, and in front of ear.

Salivary glands other than parotid occasionally are involved.

Education of patients past puberty regarding possibility and seriousness of complications.

One visit to all cases over 10 years for education, if not seen by physician. No other visits unless for nursing care, so that bed rest will be maintained.

GERMAN MEASLES

Usually mild. Complications rare. Control impractical. May be confused with measles or scarlet fever.

Differential diagnosis

No involvement of oral mucous membranes. Rash involves face. Post auricular glands enlarged bilaterally.

Only nursing care when needed.

No visits unless for nursing care.

MEASLES

May be severe. Complications are frequent, especially in young or weak children. Control impractical.

To get the child under medical care as soon as possible. To inform the family concerning the use of possible

One visit to all children under two years of age (unless definitely known to have regular medical care). More v-

EMERGENCY NURSING IN COMMUNICABLE DISEASE

What the Public Health Nurse Should Know About:

MEASLES (Continued)

Secretions from nose, throat, eyes, and mouth highly infectious in the first few days of disease.

Mortality relatively high in young children 6 months to 2 years. Attack usually confers lasting immunity.

WHOOPIING COUGH

A prolonged illness, extremely severe in infants under 1 year of age. Early recognition is important to prevent spread, but early recognition is difficult because the cough does not develop typical signs until the second or third week of the disease.

The nurse should be suspicious of any child with a paroxysmal repetitious cough that begins mildly and becomes progressively worse.

Immunization of infants with a Sauer type vaccine at 6 months of age should be urged. Use of this vaccine appears promising in diminishing the number of susceptibles and decreasing the severity of this disease. Maximal immunity is reached about 4-6 months after injections.

No vaccine is believed of value in the treatment of exposed children or those who already have the disease.

Control by isolation is impractical.

DIPHTHERIA

A serious disease. Deaths due to cardiac involvement or respiratory obstruction.

Control: (1) Patient—by isolation and quarantine (2) carrier—by isolation (3) prophylaxis—active, diphtheria toxoid; passive, diphtheria antitoxin which affords temporary protection for exposed children.

Public Health Nursing Objectives

immunizing agents for exposed young or weak children (convalescent serum, whole blood, or placental extract.) If not under medical care, watch for complications: early, broncho-pneumonia; later, otitis media and mastoiditis.

To recognize or be suspicious of whooping cough as early as possible in order to prevent spread by the isolation of suspects. To prevent exposure of infants to suspicious coughs by urging removal from the source of exposure.

To build up the number of artificially immunized children in the community.

1. To aid in proper treatment, urging hospitalization if possible.

2. To assist in epidemiological investigation and control of the patient and carrier.

3. To disseminate education for active immunization.

Minimum Visits Required

its if the home conditions, intelligence of the mother and condition of the child as seen on the first visit indicate their necessity. No visits to school age children unless for nursing care.

Same as "minimum visits required" for measles, above.

One visit if the patient is hospitalized provided negative cultures are obtained on all other members of the household.

If the patient is not hospitalized nursing visits must be planned to complement the visits of the physician, to give or supervise nursing care and to observe exposed susceptible

PUBLIC HEALTH NURSING

What the Public Health Nurse Should Know About:

Public Health Nursing Objectives

Minimum Visits Required

DIPHTHERIA (Continued)

Diagnostic leads

Cultures should be taken of:

1. All sore throats with membrane or exudate.
2. All cases of bloody nasal discharge which excoriates the lip.
3. All cases of croup, particularly when there is loss of voice.

SCARLET FEVER

A disease that may range from a mild to serious form. The disease is primarily a hemolytic streptococcus throat infection, with rash as a secondary feature. The disease may result from any human strain of hemolytic streptococcus. Every scarlet fever case is caused by the hemolytic streptococcus, but not every hemolytic streptococcus infection is scarlet fever. Every sore throat or running ear constitutes a potential menace to the public health and may give rise to as many secondary cases of scarlet fever as an actual primary case of scarlet fever.

SMALLPOX

A serious to mild, highly communicable disease.

It may prevail in any climate. There is very little natural immunity.

If it were not for vaccination, it probably would be a universal disease of childhood.

The disease has practically vanished in localities where vaccination is thoroughly practiced.

It is communicable from 2 or 3 days before onset of symptoms.

Prodromal symptoms are severe.

1. To provide adequate isolation and quarantine for the patient in order to prevent spread.

2. To assist in the epidemiological investigation and control measures under direction of the health officer. To take nose and throat cultures when indicated.

3. To educate regarding the manner of infection and control methods.

4. To discuss complications and urge adequate rest to prevent their occurrence.

Universal, repeated immunization.

Education to this end.

Required vaccinations of all school children.

Isolation of the case and immediate vaccination of contacts.

cases closely for possible symptoms, in addition to taking initial cultures of all household members. The nurse should also visit occasionally during convalescence, the second and third week, to watch for possible sequelae (cardiac and neurological) and to take cultures before discharge. (If physician is responsible for taking cultures naturally the nurse would not need to visit for this purpose.)

Visits should be planned to complement medical attention.

At least one visit at the onset to give quarantine and isolation instructions and at least one during convalescence to check on occurrence of complications, and to release convalescents from quarantine.

More visits may be required to provide either nursing advice or care or both.

1. To maintain quarantine and obtain vaccination of all contacts.

2. For nursing care if needed.

3. For release

EMERGENCY NURSING IN COMMUNICABLE DISEASE

What the Public Health Nurse Should Know About:

Public Health Nursing Objectives

Minimum Visits Required

SMALLPOX (Continued)

There may be a prodromal rash.

The true eruption is macular, papular, vesicular, and then pustular in character, usually first appearing on forehead and temple, then spreading over the body. The soles and palms are usually involved. Vesicles consist of many compartments. Papules become umbilicated. May leave severe scarring. A case is considered communicable until all lesions have healed.

MENINGOCOCCIC MENINGITIS

A severe disease. Usually epidemic in crowded areas such as camps and dormitories, civilian or military.

Infection usually takes place by contact with nose or throat secretions of a case or carrier.

Carriers play an important part in spread.

Sulfonamides are of great value in treatment.

POLIOMYELITIS

Ranges from a disease that may be so mild as to be unrecognizable to a severe and fatal disease. Caused by a filterable virus. Opinion is divided on the portal of entry and method of spread. Until recently the majority of workers considered that the respiratory passage constituted the pathway of infection. Recently the virus has been demonstrated in the feces and in sewage and this points to the possibility of its dissemination through flies and sewage, the portal of entry and mode of spread being the gastrointestinal tract.

TYPHOID FEVER

A severe disease, it is spread directly from feces of cases

To get patient hospitalized if at all possible.

To assist the health officer in epidemiological investigation and control of case.

Isolation of the patient.

1. Isolate patient to prevent spread.

Entirely dependent on hospitalization. If case is hospitalized more than one visit is not indicated. In home-treated cases nursing care is important.

One visit to instruct regarding isolation. When the Kenny method is used, the acute stage is the vital period for nursing care. Daily visits are necessary to demonstrate to the mother the application of hot packs.

1. A visit for instruction is imperative.

PUBLIC HEALTH NURSING

What the Public Health Nurse Should Know About:

TYPHOID FEVER *(Continued)*

or carriers, or directly by flies, polluted water, milk, and shell fish contamination.

Public water supplies and pasteurized milk sources rarely carry typhoid bacilli.

Control measures are usually satisfactory.

An appreciable percent of cases subsequently become carriers.

Diagnosis

1. Blood culture usually positive during first week.

2. Widal positive after tenth day.

3. Stool and urine usually positive after second week.

A typhoid vaccine is recommended for immunization of people who are going to live under conditions which expose them to this germ.

PARATYPHOID

Similar to typhoid fever. Usually milder and shorter.

DYSENTERY, BACILLARY

Ranges from a mild sub-clinical to a severe and fatal disease.

Diarrhea with blood and mucus, accompanied by fever, suggests this diagnosis.

The spread is similar to typhoid fever.

Control: Similar to typhoid fever except (1) no vaccine exists for prevention (2) sulphonamide drugs offer promise in the treatment of severe cases.

ENDEMIC RICKETTSIAL DISEASES

Endemic Typhus Fever

Rocky Mountain Typhus Fever

a. Eastern

b. Western

This group of diseases are caused by rickettsial organisms, which appear to occupy

Public Health Nursing Objectives

2. Education of family and attendant in proper disposal of excreta.

3. Investigate source by checking:

a. Water, milk, and food supply.

b. Sanitation of the environment: disposal of excreta and fly control.

c. Existence of carriers.

Two negative cultures of the stool and urine are absolute minimums for the discharge of a case.

Each case of typhoid fever should be made an educational experience for the patient, family, and community.

Prevention of cases by use of typhoid vaccine among people living or expecting to live under conditions which might expose them to typhoid fever.

Minimum Visits Required

2. Check up on how instructions are being carried out.

3. Nursing care when necessary.

4. Volunteer may be used to pick up specimens before discharge, but the nurse should give the family instructions as to the method of collection.

5. Nursing supervisory visits to known carriers; 3 visits per year. These might be office visits.

Same as for typhoid fever.

Same as for typhoid fever.

Similar to typhoid fever.

Same as typhoid fever.

Health education as to the etiology and elimination of possible future hazards.

Visits for nursing care only

EMERGENCY NURSING IN COMMUNICABLE DISEASE

*What the Public Health Nurse
Should Know About:*

*Public Health Nursing
Objectives*

Minimum Visits Required

ENDEMIC RICKETTSIAL DISEASES *(Continued)*

an intermediate position between bacteria and viruses.

They range from moderate to severe and last almost as long as typhoid fever.

All of them are characterized by some degree of petechial rash and by a positive blood serum agglutination known as the Weil-Felix reaction.

The vector varies with each disease, being usually

1. The wood-tick for Western Rocky Mountain Spotted Fever.

2. The wood- or dog-tick for Eastern Rocky Mountain Spotted Fever.

3. The rat-flea for endemic typhus fever.

Vaccines against some of these diseases are available for protection of individuals going to areas where they may be exposed.

TYPHUS FEVER EPIDEMIC

A serious disease. Spread via body lice. Not a problem in the United States at present, but may become one when soldiers return.

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Industrial Rehabilitation of Permanently Injured Workers

By EDWARD C. HOLMBLAD, M.D.

BY REHABILITATION in medicine we refer to the methods of treatment and management that help an injured, sick, disabled or handicapped person to recover his former abilities or to develop new powers that add to his physical, economic, and social welfare.

In discussing rehabilitation of permanently injured workers we recognize that these may be of a great variety and of various degrees. Some of these permanent injuries may involve only one extremity, or the entire body may be involved. We must also recognize that we have to deal with actual physical disabilities while others may be mental disabilities or various types of neuroses, including such as traumatic neuroses and shell shock.

The disabling episode may be brought about by disease, such as infantile paralysis, arthritis, heart disease, et cetera, or by accidental injury. A great deal of the success of any rehabilitative program is markedly influenced by the thoughts, ideas, and experiences that take place early in such a disabling experience. We must recognize the very serious influence of fear and phobias during this early stage. Some people are better equipped than others to overcome these fears, and patients face periods of disability with a variety of attitudes. Some people actually welcome a disabling condition because it constitutes an escape mechanism from some unpleasant situation or status. Others face disability in a staid attitude

or resignation to whatever may be in store for them—sort of a neutral attitude. Still others face a crippling disability with an attitude of challenge. These are the positive, aggressive, cooperative, individuals that are the source of great joy and happiness to treating physicians, surgeons and a physical therapist.

PATIENT'S ATTITUDE

So important is this initial attitude of the patient that the success or failure of rehabilitation frequently depends upon it. Quite early in a disability a patient will purposely (consciously) or unintentionally (subconsciously) make up his mind regarding the advantages of being disabled. The prospect of long periods of drawing compensation, insurance and lodge benefits or anticipated sums of money for permanent damage settlements may be the influencing factors. Then we see those partial cripples or partial invalids who enjoy (even though they won't admit it) the attention, care and freedom from responsibility that their disability gives them. Some one else earns their livelihood and provides the necessities of their existence and care.

In treating injured persons the physician quite early forms an opinion about the injured person's attitude towards his injury. Correctly to recognize and diagnose these attitudes and to plan treatment to modify and correct them is the ambition of every treating physician and surgeon.

REHABILITATION OF INJURED WORKERS

One of our first duties as physicians is correctly to enlighten our patients about their conditions. Arthritis, heart diseases, and even infantile paralysis are not necessarily associated with permanent disability and we must overcome this initial blow that such a diagnosis may create. Too many patients with fractures of the transverse processes of the lumbar vertebra gain the impression that they have a broken back, when in reality a fractured transverse process is nothing more than a fractured rib, should be so treated, and the patients should get well just about as fast as a case of fractured ribs. The experience of placing a fractured leg at or near the ankle joint, into a walking iron and allowing the patient to get up and walk about yields great satisfaction not only to the patient but also to the treating surgeon. Then when the cast is removed, this patient avoids that painful period of swelling and stiffness so often seen when weight bearing is not permitted.

We have no better rehabilitative physical therapy treatment than purposeful, natural usage within the patient's tolerance. Every patient wants some specific evidence from day to day that he is getting better. We must establish the confidence of the patient to do the things within his tolerance. Most all patients get a real thrill when they can walk without crutches or a cane; when they can walk up or down stairs.

The success of rehabilitation really depends on the patient's "will to get well." This is a first prerequisite. If this is lacking, then our task has become much greater because we have to encourage, nourish, and develop in our patient this will to get well before we can show much in the way of results. In talking with patients and encouraging them in their progress, I frequently develop the idea that there is a "real thrill" in getting well. When once they ex-

perience the gratification of improvement and actually get a thrill of getting well, then steady and real progress is assured.

There are many inhibiting influences in a rehabilitative program that must be overcome. We have the fears and influences of over-cautious relatives or friends and sometimes over-cautious physicians or nurses. I have seen an over-anxious foreman or employer completely disrupt a rehabilitative program by insisting that plaster of paris casts be applied to fractures without displacement or providing crutches to patients when the attending surgeon wishes the patient to use the foot or leg in walking. Probably all well-intentioned acts, but nevertheless interfering with recovery.

FACTOR OF DISABILITY PAYMENTS

There are some insurance companies who do not pay total disability benefits if the patient does any remunerative work. Such denial of benefits occasionally stands in the way of getting a patient back to light work, operating elevators or acting as a watchman. Some of the leading far sighted insurance companies have worked out a plan to pay the benefits during the rehabilitative treatment working period which is really the best occupational therapy. In many instances, patients with coronary thrombosis, arthritis, certain lung diseases and neurosis, et cetera, have been fully rehabilitated to full working and former earning capacity by such a period of demonstrating to them their ability to work. These are the functions of curative work shops, occupational therapy clinics and such enterprises as the Good Will Industries, doing a splendid piece of work all over this country.

The job placement of handicapped workers opens up an excellent field for rehabilitation of the permanently injured or disabled person. The cooperative

attitude of most employers in providing suitable or modified work for their injured employees is most commendable and does a lot to rehabilitate these employees. Many of them are appreciative and are better employees after such an experience.

The influence of competent industrial physicians and surgeons heading up the medical departments of many industries has been distinctly noticed in the job placement of handicapped workers during the last decade. Dr. Daniel Lynch of Boston by his persistent devotion to such a course has rehabilitated many workers who were slated for early retirement because of disabling conditions. Patients with crippled hands are re-educated to do certain types of clerical and office work. Many telephone operators threatened with retirement because of decreased hearing are rehabilitated and kept at work by a combination of amplification of the telephone receiver with a hearing aid device.

What it takes is the ingenuity and persistence of someone sufficiently interested to find the type of work that these handicapped or disabled persons are able to do.

In this connection it should be emphasized that these patients do not want sympathy or special consideration. It means a great deal to them to be able to carry on actively and to accomplish the same type of work as their fellow employees. These rehabilitated persons want to earn their salaries and wages the same as anyone else. They do not wish to be looked upon as creatures of charity, sympathy, special consideration nor special privileges. They want to stand on their own right, proud of their achievement. We owe them this recognition.

I should like to present three cases of persons who have rehabilitated themselves from permanently disabling conditions to practically complete rehabilitation. All are earning at least the same

or more wages and salaries than they were prior to their disabilities.

CASE HISTORIES

I. R. D. is an employee of the Railway Express Agency who started to work as a platform man and express handler in 1923. In August 1929, he was taken ill with arthritis of his dorsal and lumbar spine, so frequently called rheumatism. His condition was characterized by repeated episodes of lumbago-like attacks of intense pain and spasm that would put him to bed for weeks at a time. His children then were 2 sons and 3 daughters, ages 1-5-6-9-12 years. With his wife and himself he was responsible for a family of seven. In 1930 after an adequate period of conservative treatment had been carried out, he submitted to a spinal fusion as offering him the best prospect of permanent relief. This operation was done at St. Luke's Hospital in Chicago, 1930.

In this operation his lower vertebrae were fastened together by fusion into one piece of bone thus relieving the pain in his back by eliminating painful joints and ligament movements. He remained in the hospital 4 months, had a convalescent period of 1 month, and resumed his occupation as a platform man and express handler in June 1930, where he has been working ever since. He now works nights from 7 p.m. to 3 a.m. earning more money than he did before his disability and proud of his achievement. I am informed by his foreman that "D" does as much and frequently more work than other able-bodied fellow workers. He is a most desirable employee.

II. R. McC., age 50, is an electrician who slipped and fell sustaining an intertrochanteric fracture of his right hip on February 16, 1942. He had rehabilitated himself to such a degree that he astonished me by walking into the office June 16, 1942 using nothing but a cane. A month later he had discarded this cane.

He resumed his work as an electrician on August 5, 1942. Although he is assigned to bench work repairing switches, motors and other electrical devices, he chooses to stand at his bench most of the time rather than sit down.

III. C. H. who has been a nurse associated with me in carrying out rehabilitative treatments following injury for 15 years, was unfortunate enough to sustain serious injuries as a result of an automobile accident June 25, 1941. One of the other passengers was killed immediately; the driver of the car died a few days later without regaining consciousness. She and one other passenger survive. Her injuries were so serious that she hovered between life and death for over three weeks much of the time being kept alive only by intravenous fluids and blood transfusions at frequent intervals. Her injuries consisted of:

- Multiple fracture of pelvis
- Multiple fractures of six ribs right chest
- Compression fracture 8th dorsal vertebra
- Fracture dislocation right foot tarsal area
- Fracture of right tibia extending into knee joint
- Extensive hemorrhage into left thigh with necrotic slough and subsequent skin graft
- Internal injuries of abdomen with laceration of liver and hemorrhage

She owes her life to the conscientious and untiring efforts of Dr. Nelson K. Forester who stayed constantly with her several nights, administering fluids, transfusions and medications. After the

third week her previous experience in rehabilitation stood her in good stead as she knew what to do and proceeded to do these things, such as movements of her right foot and knee that prevented ankylosis; skin grafting later covered large area of skin sloughing. She carried out use of slings and pulley devices for movements of her arms and legs. Passive, active and resistive exercises were started and increased quite rapidly. She surprised her physician one morning by demonstrating her ability to turn over in bed. Later on she sat on the edge of the bed, then in a chair. Later she started to put weight on her legs and still later became ambulatory.

On October 28, 1941, she left the hospital and convalesced with relatives, making her first trip to Chicago, January 17, 1942. She started coming down to work in the office a few hours a day, January 19, 1942, gradually increasing this length of time so that April 15, 1942 she started doing a full day's work. She has been doing this full day's work regularly since. She is actively engaged in giving rehabilitative physical therapy treatments. She is all the more competent now talking to these patients with the benefit of her experience and knowing what they are going through in the way of pain and agony, but also knowing the thrill and gratification of getting well which is the reward achieved by those disabled persons who have a genuine desire and real will to get well.

From a talk delivered before the National Safety Council's 31st Annual Safety Congress, October 29, 1942, Chicago, Illinois. Published with permission of *Archives of Physical Therapy*, in April issue of which this article is also appearing.

Your Education Committee

By LEAH M. BLAISDELL, R.N.

HAVING RECENTLY had the privilege as its new chairman of acquainting myself more intimately with this Committee, it occurred to me that other members of our Organization might be interested in sharing that orientation so that all would know how to make the Committee work effectively for both the individual and the profession.

This Committee has an illustrious history. It was organized in 1916 with Katharine Tucker as its first chairman. The minutes of its meetings through the years contain a wealth of information indicative of profound thinking on problems of vital concern to our professional growth.

The general functions of this Committee are implied in its title. A major portion of its time, however, particularly in the past 10 years, has been devoted to the development and approval of university programs of study in public health nursing for staff nurses. Of the 32 programs approved as of January 1943, 19 were accredited during the present decade. The remaining time has been given to preparation of recommended qualifications for public health nursing personnel (revised and printed in the magazine every five years), public health aspects of the curriculum in undergraduate schools of nursing, staff education, and the preparation of supervisors. Many other functions have been suggested, but remain undeveloped because of insufficient personnel to do the work. Mary C. Connor, assistant director of the N.O.P.H.N., is the secretary of the

Education Committee. In later issues of the magazine, Miss Connor will tell of her work and try to clear up questions which may puzzle you.

In carrying out these functions, the Committee has wisely worked with other organizations through joint committees and subcommittees in the pattern illustrated in the chart. Although this plan may appear complicated at first, it does tend to avoid duplication and strengthen action to join forces in this fashion.

The Education Committee is selected to give wide geographical representation as well as a diversity of points of view. About one-third of its 23 members are representatives from universities, one-sixth are from private and one-sixth from official agencies—the remaining third are selected for the special contributions which they can make in their respective capacities as a lay member, a Negro nurse, a basic nursing school educator, and a nurse with wide international experience. The Committee meets annually at the A.P.H.A. convention, and its Executive Committee is active during the rest of the year—meeting to transact business whenever occasion arises.

The present Education Committee, whose membership is listed in the December 1942 issue of PUBLIC HEALTH NURSING, held its first meeting in St. Louis in October 1942 when plans for the coming biennium were made.

At this meeting after careful consideration the Committee recommended, and subsequently the N.O.P.H.N. Board of Directors approved, a realignment of activities. A brief progress report on

YOUR EDUCATION COMMITTEE

each is given hoping it may suggest questions you would like answered or suggestions you would like to make. Here is your opportunity!

1. Accreditation of Postgraduate Programs of Study in Public Health Nursing

Accreditation has many pitfalls. Multiplicity of accrediting bodies, tendency to standardize and hamper experimentation are fully appreciated, but national thinking still concludes that the values of protecting students, stimulation of schools to improve, and the exchange of good methods offsets its disadvantages.

The Committee would like to have accreditation done jointly with the National League of Nursing Education and the Association of Collegiate Schools of Nursing, thus having only one nursing accrediting agency. Although financially impossible right now, efforts will be made to find funds to do this soon. In the meantime, a small Subcommittee on Accreditation has been appointed under the chairmanship of Ruth Hubbard of Philadelphia to carry out the policies of accreditation set up by the Education Committee. This Subcommittee meets three or four times a year. Miss Hubbard has promised to write for the magazine soon a short interpretation of this activity giving the essential requirements of an "approved program of study," describing the new annual surveys that have been initiated this past year by which universities will be helped and judged for continuation of approval.

Some of the collegiate undergraduate schools of nursing are now asking if and in what ways their courses must be strengthened to meet the approval of the N.O.P.H.N. for first-level public health nursing. Early in 1943, the first of these schools is to be surveyed jointly with the N.L.N.E. for this purpose.

The Committee hopes soon to consider essential requirements for programs of

study in supervision and in teaching in public health nursing, and possibly to assist a few more universities to develop this advanced type of program.

2. Recruitment and Vocational Counseling of Public Health Nurses

In spite of the need for nurses in the armed forces, serious consideration must be given to the need of preparing public health nurses for our own civilian population protection and for rehabilitation of health in wartorn countries after hostilities cease. Approximately 800 counties in the United States still lack any public health nursing service! Mature nurses with considerable experience in community planning are required both at home and abroad, and with present losses to the armed forces, marriage, and pregnancy, we must aggressively insist on securing the small percentage of good recruits that will make up our losses and help us gain a little momentum. If only 1 in every 10 graduates of schools of nursing could be directed into sound postgraduate preparation for public health nursing (possibly after a year's practice as a graduate nurse), we would not be in the present difficult position of appointing nurses to rural positions or other positions of considerable responsibility with no preparation in this field. It is unfair to the community which then receives a mediocre service, and it is unfair to the nurse who, though fundamentally competent, is as unprepared for community education and leadership as is a Volunteer Nurse's Aide for undertaking full responsibility for care of a tiny premature infant! We hope to have every public health nurse, at least those on the supervisory level, working together on this "1 in 10 plan" during the coming year.

Possibly our greatest bottleneck, however, is that of insufficient supervisors and teachers in public health nursing.

PUBLIC HEALTH NURSING

We must develop that group as rapidly as possible. How to do this most quickly and effectively is the vocational guidance aspect on which again we need and anticipate the help of all.

3. Integration of Public Health in the Basic Curriculum

Work through the Joint Committee on Integration of Public Health in the Basic Curriculum with the N.L.N.E. will be continued. Charlotte Skooglund of the Philadelphia General Hospital School of Nursing is chairman of this Joint Committee and at present the group is surveying various methods of integration now in practice.

4. Staff Education

We cannot afford, even with present pressure of work, to neglect this vital aspect of our growth. It seems well agreed that the positive approach of giving considerable help to those with greatest assets should be one of our avenues to securing the leaders we need. Among staff education problems on which the Committee hopes to secure and exchange good ideas are the following:

- Discovering needs of the staff
- Suiting the needs of individuals
- Combining efforts of various groups in the community
- Utilizing the help of universities
- Determining the time justified in staff education.

5. Student Field Experience in Post-graduate Programs of Study in Public Health Nursing

Approximately 100 agencies are used at present as experience centers for graduate nurse students in public health nursing. Without running the danger of

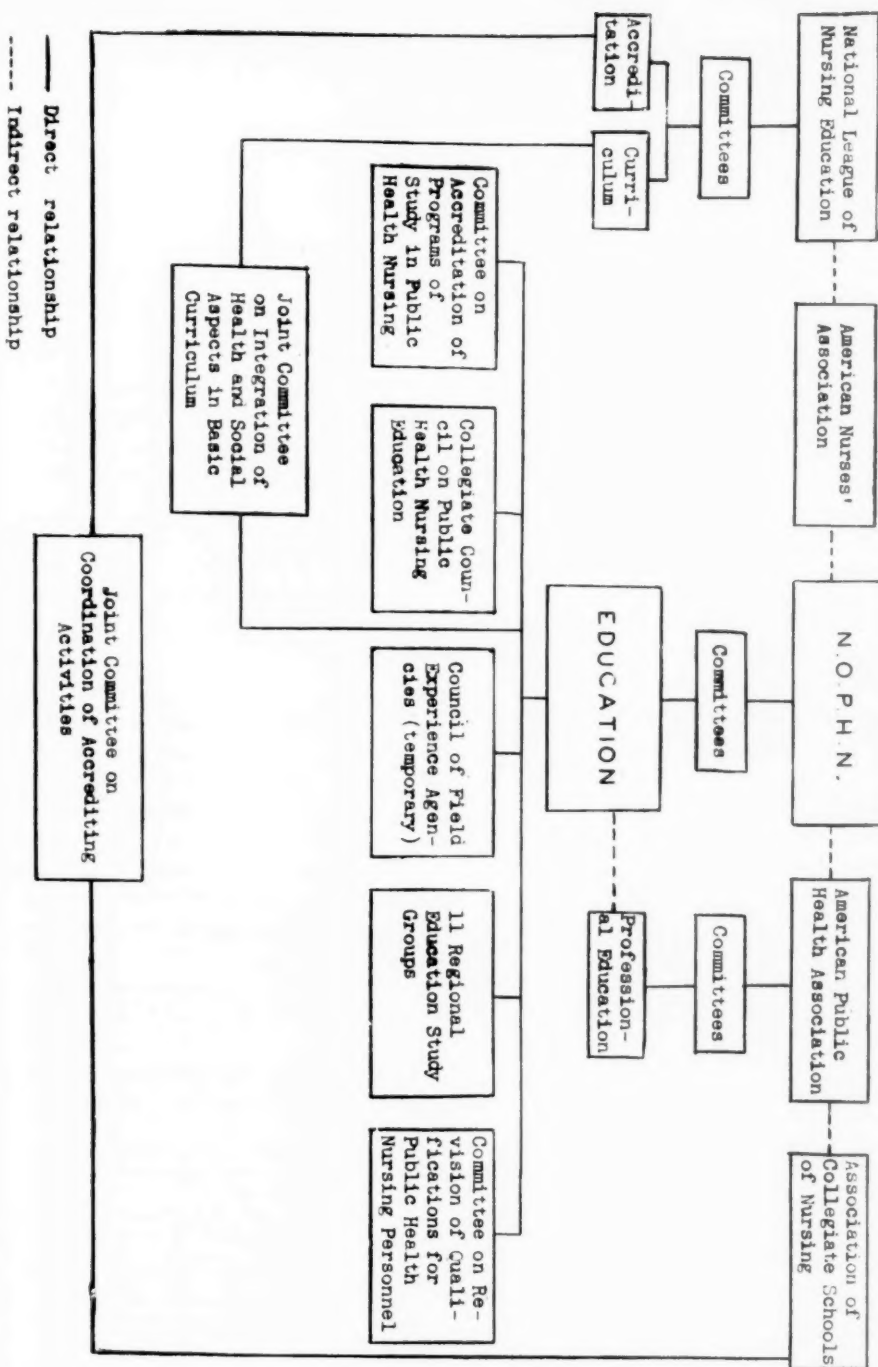
too much standardization, it is believed that these agencies which assist students in such a variety of ways might profitably exchange ideas and work out some guiding principles about field experience valuable to themselves, to the students, and to the universities they represent. It is hoped that intensive work through correspondence, and when possible two or more annual meetings at the time of A.P.H.A. conventions, may lay a groundwork, after which the Special Council of Agencies Offering Field Experience to Public Health Nursing Students, authorized by the Board of Directors of the N.O.P.H.N., may be discontinued.

6. Collegiate Council on Public Health Nursing Education

The Collegiate Council on Public Health Nursing Education, formerly called the Council of Course Directors, is composed of the 32 public health nurses in charge of approved programs of study in public health nursing. Eula B. Butzerin of the University of Chicago is its present chairman, and will present a brief story of the activities and thinking of that group in a forthcoming issue of the magazine. This group acts as a subcommittee of the Education Committee and threshes out problems of organization and administration of the school, selection of students, content of theoretical and field curricula, placement and credit.

The Education Committee is YOUR committee. It welcomes questions and requests. We want to meet your needs. If we do not, write us or report to Marion G. Howell, president of the N.O.P.H.N.

Relationship of the N.O.P.H.N. Education Committee to Other National Nursing Organizations and the American Public Health Association



Changes in Public Health Nursing Salaries

BY DOROTHY E. WIESNER AND MARGARET M. MURPHY

Part I. *Salaries, 1938-1942*

WHEN THE public health nursing agencies were selected for the National Organization for Public Health Nursing salary study of 1942, efforts were made to include all those that had given data for the 1938 salary study.* The returns make possible this comparative study, since salary information was returned by 392 local agencies for both years.** These include 196 nonofficial agencies; 185 official agencies, of which 67 were municipal health departments, 42 were county health departments, 76 were departments of education; and 11 combination agencies. The 392 agencies employed a total of 7,145 nurses in December 1938, and 7,242 nurses in January 1942.***

Salaries paid public health nurses by these agencies in December 1938 and January 1942 were studied according to the position of the nurse on the staff and the size of the agency in 1942. For those agencies employing more than one nurse in any of the positions considered, the median salary for that position was used as a measure for comparison. Some of the small agencies in reporting the salary of the nurse-in-charge for both years used the term "director" in one instance and "general supervisor" in the other. In such cases, the title given the nurse in 1942 was used for both periods. If only one nurse was employed by an agency, she was classified as a "generalized" staff

nurse." Salaries have been tabulated by ten dollar intervals. A salary could vary within the interval, from \$140 to \$145 for example, without appearing as an increase in our tables.

SALARY CHANGES BY POSITION ON STAFF

Table I shows changes in salaries by type of employing agency and positions on staff.

Director

Salaries of directors were reported for both periods by 225 of the 392 agencies in this study. More than half of these, 55 percent, reported no changes in salary for the director since 1938. In 37 percent, the director's salary had increased since that year, in 8 percent had decreased. In some instances decreases are explained by changes in directors since 1938, and the fact that beginning salaries are often less than those paid after years of service.

A tabulation by size of agency shows that relatively more increases occurred in

*For complete report of 1938 salary study see "Going Forth," PUBLIC HEALTH NURSING, November 1939, page 624.

**In addition, 37 state departments of health reported for both years, but these are not considered in the present analysis. See "State Salaries in Public Health Nursing," PUBLIC HEALTH NURSING, August 1942, page 455.

***For report of 1942 salary study of 645 local agencies, see "Salaries in Public Health Nursing, 1942," PUBLIC HEALTH NURSING, December 1942, page 690.

SALARY CHANGES

TABLE 1
CHANGES IN SALARIES IN 392 PUBLIC HEALTH NURSING AGENCIES, 1938 TO 1942

By type of agency	Agencies by salary ¹ variations in certain positions														
	Director			Generalized supervisor			Specialized supervisor			Generalized staff nurse			Specialized staff nurse		
	Increase	Same	Decrease	Increase	Same	Decrease	Increase	Same	Decrease	Increase	Same	Decrease	Increase	Same	Decrease
Total agencies reporting position both years ²	82	124	19	54	56	9	10	25	4	148	168	41	26	22	9
Nonofficial	48	76	11	36	39	6	5	15	3	74	88	24	14	10	.....
Health departments:															
Municipal	13	24	.....	10	11	.....	4	8	1	22	25	2	9	10	6
County	7	8	3	7	4	3	1	.....	.....	14	19	7	3	1	2
Departments of education ³	9	12	4	.....	.....	.....	.....	.....	.....	29	34	8	.....	.....	.....
Combination agencies	5	4	1	1	2	.....	.....	2	.....	9	2	.....	.....	1	1

¹The median salary has been used as a measure for comparison between the two years for those agencies employing more than one nurse in any one position.

²Some agencies did not employ nurses in all of the five positions studied for this table: one-nurse agencies, for example, do not appear in the columns headed director, generalized supervisor, or specialized supervisor.

³In this group of agencies, the term "generalized staff nurse" includes the nurses who perform all the services included in the program of the agency.

PUBLIC HEALTH NURSING

the smaller agencies. Only four increases were reported by 28 agencies employing 50 and more nurses in 1942. All four were directors in municipal health departments. In the group of 101 agencies employing 10 to 49 nurses, 33 agencies showed an increase in the director's salary. In the 96 small agencies, employing less than 10 nurses, 45 agencies, almost half, reported increases.

Generalized supervisor

Salary data for generalized supervisors were reported by 120 agencies. Of these, 47 percent reported no change in such salaries from 1938 to 1942. Almost the same proportion, 45 percent, indicated an increase. Of 23 large agencies, employing 50 or more nurses, 11 increased generalized supervisors' salaries. Of 62 agencies employing 10 to 49 nurses, 27 indicated increases. Of 35 small agencies, employing less than 10 nurses, 16 reported an increase in salary to the generalized supervisors. Only 10 agencies showed decreases.

Generalized staff nurse

In this sample of 392 agencies, 357 reported complete salary data in both periods for the generalized staff nurse.

No change in salary for these nurses was indicated by 47 percent. Increases in salary were made by 42 percent of the agencies.

By size of agency, 10 of the 28 large agencies reported increases to generalized staff nurses. In the group of 113 employing 10 to 49 nurses, 41 percent indicated increases. Of the 216 small agencies, employing less than 10 nurses and including the one-nurse agencies, 43 percent reported increases. Agencies reporting decreases numbered 41, or 12 percent, of the total 357 agencies. The lower salaries for 1942 in these agencies are probably explained by turnover in staff, or additions to the staff since 1938.

Salary data reported for specialized supervisors and staff nurses were too few to be analyzed by size of agency. Changes in salaries for these positions can better be discussed by type of employing agency.

MEDIAN SALARIES BY TYPE OF EMPLOYING AGENCY

Table II shows what salaries were paid in 1938 and 1942 by a group of agencies for the positions listed in both years.

Nonofficial agencies

The median salary in 1938 for the di-

TABLE II
MEDIAN SALARIES OF PUBLIC HEALTH NURSES, DECEMBER 1938 AND JANUARY 1942

By type of agency	By position on staff									
	Director		Generalized supervisor		Specialized supervisor		Generalized staff nurse		Specialized staff nurse	
	1942	1938	1942	1938	1942	1938	1942	1938	1942	1938
Nonofficial	\$221	\$216	\$164	\$158	\$167	\$169	\$133	\$129	\$144	\$136
Health departments:										
Municipal	219	208	177	170	170	170	143	135	139	142
County	213	204	168	161	....²	....²	138	134	....²	....²
Departments of education ¹	2340	2310	....	....	....	....	1680	1656	....³	....³
Combination agencies	238	231	....²	....²	....²	....²	148	142	....²	....²

¹Median yearly salary is given for nurses in departments of education. School salary covers the school year (9 to 11 months) and hence cannot be stated as monthly figure.

²Sample is too small to obtain median.

³Data about specialized nurses in departments of education were not asked in 1938.

rectors in 135 nonofficial agencies was \$216; in these same agencies the director's median salary in 1942 was \$221.

A median salary of \$158 was obtained for generalized supervisors in 81 agencies in 1938, with a range of \$120 to \$225; in 1942 the median was \$164, with a \$120 to \$250 range.

The median salary for specialized supervisors was \$169 in 1938, but only \$167 in 1942. The 1938 range was \$120 to \$275 but in 1942 the highest salary for such work was only \$250. Salaries of specialized supervisors were higher in both periods than those paid generalized supervisors by nonofficial agencies.

Salaries for generalized staff nurses were reported for both periods by 186 nonofficial agencies. Their increase in salaries as measured by medians was small—in 1938, \$129 and in 1942, \$133. The 1938 range was \$100 to \$180; in 1942, from \$80 to \$190. There were, however, 24 agencies that reported decreases in salaries for generalized staff nurses since 1938.

Specialized staff nurses' salaries were reported by 24 agencies. The median salaries were \$136 in 1938 and \$144 in 1942. A larger increase was shown for these nurses than for any of the other nurses in nonofficial agencies. Increases in salaries of orthopedic nurses accounted in great part for the higher 1942 rates among specialized staff nurses.

Municipal health departments

In the sample of 67 municipal health departments sending in salary data for both periods, 37 reported salaries of directors of nurses. A median monthly salary of \$208 was obtained for directors in 1938 as against \$219 in 1942. This increase of \$11 among directors of municipal health departments is higher than the similar increase for directors of nonofficial agencies between these two periods.

The median salaries for generalized supervisors in 21 departments were \$170 in 1938 and \$177 in 1942, with a range in 1938 from \$120 to \$225 and in 1942 from \$130 to \$250.

The same median salary of \$170 was obtained for both years in 13 departments for supervisors or consultants in special fields.

Salaries of generalized staff nurses in 49 departments, as measured by the \$135 median in 1938 and \$143 in 1942, were higher in both periods than those of the generalized staff nurses in nonofficial agencies. In 1938 the range was \$90 to \$180 and in 1942, \$80 to \$190. The increase of \$8 in median salaries was greater than that of the generalized staff nurses in the nonofficial agencies.

A median salary of \$142 in 1938 was obtained for specialized staff nurses in 26 departments, and a lower median of \$139 for 1942.

County health departments

The median salaries for directors in 18 county health departments were \$204 in 1938 and \$213 in 1942.

Salaries of generalized supervisors were reported for both years by 14 departments. The medians were \$161 in 1938 and \$168 in 1942.

The median salary for generalized staff nurses in 40 departments was \$134 in 1938 and \$138 in 1942. In 1938 the range was \$90 to \$180 and in 1942, \$110 to \$180.

Departments of education

Salaries of the supervisor or chief nurse in departments of education were reported for both years by 25 of the 76 departments in this study. The yearly median salary was \$2,310 for the 1938-1939 school year and \$2,340 for the 1941-1942 school year.

The salaries of school nurses were reported for both periods by 71 of the de-

PUBLIC HEALTH NURSING

partments of education. The yearly median salary for school nurses in 1938-1939 was \$1,656, and for 1941-1942 it was \$1,680. Range of salaries was almost the same in both years—\$960 to \$3,000.

Combination agencies

Salaries for directors of combination agencies were reported for both periods by 10 of the 11 such agencies in this study, with a median of \$231 in 1938 and \$238 in 1942. Directors received higher salaries in both years, as measured by the median, than did directors in all other types of agencies. These directors are carrying responsibility of both official and nonofficial work.

Generalized staff nurses were better paid, too, than those in other agencies in this study. The medians were \$142 for 1938 and \$148 for 1942.

Few data were reported for other positions in combination agencies. Five generalized supervisors in 1938 received salaries ranging from \$160 to \$175 and four in 1942 ranged from \$160 to \$190. Only two of these combination agencies employed specialized supervisors, one being paid \$140 in both years, and the other, \$150. It is to be remembered that only 2 of the 11 agencies employed more than 25 nurses in 1942, the largest employing 28. Four employed less than 10 nurses.

Part II. Salaries, 1932-1942

Beginning in 1925 salary studies have appeared annually in PUBLIC HEALTH NURSING, except for the years 1931, 1939, 1940, and 1941. Table III shows fairly comparable figures for 1932 and 1942. The comparisons are not so valid as those in the preceding section of this review, because the agencies compared are of similar type and size but not necessarily the same. The median salaries for 1932 were based on data from 377 agencies,* and those for 1942, from 468 agencies.

The most noticeable change over this 10-year period, as measured by these medians, is the high rate of increase in salaries of nurses in the health departments. Salaries of directors in these departments increased 16 percent from 1932 to 1942; generalized supervisors' salaries, 18 percent; and generalized staff nurses' salaries, 8 percent.

In nonofficial agencies, salaries for the group as a whole showed little change.

The larger nonofficial agencies, with 50 or more nurses, were the only ones showing decreases for generalized supervisors and staff nurses. In agencies employing less than 50 nurses these same positions showed increases. One explanation for the decreases may be the more rapid turnover in the larger agencies. According to data reported in 1939, among some 1,500 nurses in 14 agencies employing 50 nurses and more, 32 percent had been on the staff 8 or more years. Among 160 nurses in 13 agencies employing about 10 nurses each, 45 percent had been on the staff 8 or more years. There is, of course, considerable variation as to turnover, but it is probably more rapid in larger agencies. This may be due to the prestige associated with having worked in a larger agency. The smaller agencies are perhaps more reluctant to lose the experienced workers, and have felt more inclined to raise salaries to hold their staffs. The 1942 salaries remain higher in the larger agencies, but the differences between the salaries in the larger and

*See "Salaries of Public Health Nurses, 1932." PUBLIC HEALTH NURSING, May 1932, page 253.

SALARY CHANGES

smaller agencies is less marked than in 1932.

CONCLUSION

The review of public health nursing salaries for the 10-year period, 1932 to 1942, further emphasizes the conclusion reached in the comparison of the salaries from 1938 to 1942, namely, that salaries in the health departments rose more rapidly than salaries in nonofficial agencies. It is also interesting to note that salaries of specialized supervisors apparently did not increase so frequently as did those of generalized supervisors.

These salary changes reflect certain general trends in public health nursing which have been observed by field work-

ers of the N.O.P.H.N. and other national agencies.

Since the passage of the Social Security Act in 1935, more funds have been available for public health nursing in health departments, and also for stipends for public health nursing education. Not only more, but also better qualified public health nurses are being employed. As a result of the more extensive application in official health agencies of the merit principle in personnel administration, job classifications and qualifications have been established, as well as definite salary ranges.

Formerly nursing services in health departments were administered on a specialized basis. Public health nurses were as-

TABLE III
MEDIAN MONTHLY SALARIES OF PUBLIC HEALTH NURSES IN JANUARY 1932 AND 1942

By type and size of agency	Directors		Generalized supervisor		Generalized staff nurses	
	1942 ¹	1932	1942	1932	1942	1932
Nonofficial agencies, all sizes	\$220	\$225	\$167	\$165	\$133	\$135
50 and more nurses	415	415	170	175	138	140
25-49	275	275	163	160	132	125
10-24	253	275	163	150	128	125
2-9	195	190	166	150	128	125
Health departments, all sizes	206	180	207	175	157	145
50 and more nurses	250	225	210	180	163	145
25-49	225	185	175	150	116	125
10-24	210	180	168	155	134	120
2-9	169	170	168 ³	— ²	146	135
Departments of education, all sizes	2187 ⁴	2100 ⁴	—	—	1763 ⁵	1760 ^{5,6}

¹To compare median salaries of directors in these two periods, it was necessary to recalculate 1942 medians for directors without including salaries of assistant directors, because in 1932 directors' salaries only were included. The 1942 median salaries for these nurses therefore differ from those given in the summary table of the study in the December issue of PUBLIC HEALTH NURSING.

²Insufficient number of cases.

³Actual salary of middle person.

⁴In this group of agencies these nurses have title of supervisor or chief nurse.

⁵In this group of agencies "generalized staff nurse" means that the nurse performs all the services included in the program of the agency.

⁶In 1932 sample, more than half of the 2,031 nurses who were engaged in school nursing were employed by Boards of Health; in the 1942 sample, all of the 1,131 nurses were employed by Boards of Education.

PUBLIC HEALTH NURSING

signed to special service units such as child health or communicable disease. Nurse supervisors were often employed for each of these special groups. Now more health departments administer public health nursing on a generalized basis, whereby each nurse giving direct service includes in it all types of nursing care for which the department is responsible. As a result, more health departments now have public health nursing divisions

which serve all service units requiring public health nursing. Hence, specialized supervisors are gradually disappearing as administrative personnel along with specialized staff nurses and are being replaced by generalized supervisors and generalized staff nurses. Consultants in special fields are being added to public health nursing units in health departments, but as educators rather than administrators.

INVALID DIETS AND FOOD RATIONING

OF INTEREST to all who are concerned with diets for invalids is Ration Order 13, issued by the Office of Price Administration under date of February 9, 1943. This order covers all canned, dried, and frozen fruits and vegetables. Article II, Section 2.5 of the order reads as follows:

Consumers who need more processed foods because of illness may apply for more points.

(a) Any consumer whose health requires that he have more processed foods than he can get with War Ration Book Two, may apply for additional points. The application must be made, on OPA Form R-315, by the consumer himself or by someone acting for him, and may be made in person or by mail. The application can be made only to the board for the place where the consumer lives. He must submit with his application a written statement of a licensed or registered physician or surgeon, showing why he must have more processed foods, the amounts

and types he needs during the next two months, and why he cannot use unrationed foods instead.

(b) If the board finds that his health depends upon his getting more processed foods, and that he cannot use or cannot get unrationed foods, it shall issue to him one or more certificates for the number of points necessary to get the additional processed foods he needs during the next two months.

The application form referred to above, OPA Form R-315, is apt to be somewhat confusing to patients. It is titled "Sugar Special Purpose Application" and was developed primarily to meet the need for home canning. It is being used temporarily, until a more adequate form can be gotten out.

It is anticipated that the procedure indicated in Section 2.5 above may be changed somewhat in the future, in which case due notice will be provided.

National Health Council

LOOKING Ahead at National Health" was the theme of the annual meeting of the National Health Council on March 16, at which time the highlights in the past year's activities of the Council were presented by Dr. George Stevenson. Officers re-elected for the coming year are: Dr. George Stevenson, president; Dr. Kendall Emerson, vice-president and chairman of the Executive Committee; Mrs. Eleanor Brown Merrill, secretary, and Dr. William F. Snow, treasurer. The Board of Directors for 1943-45 are: Dr. Louis I. Dublin, Metropolitan Life Insurance Company (representing American Public Health Association); James L. Fieser, American Red Cross; Ruth Houlton, N.O.P.H.N.; Dr. Albert McCowan, American Red Cross; Dr. Nathan D. VanEtten, representative at large; Dr. N. P. Nielson, National Education Association (representative at large); Dr. Ray Lyman Wilbur, president, Stanford University (representing American Social Hygiene Association).

Speaking about futures in health at the luncheon meeting, Lawrence K. Frank said, "I prefer to use the phrase, 'Peering through the fog.' It is not so important that we should all see the same things, but it would help if we could all look in the same direction. There are perhaps two major channels of approach to the future. We may try to build a world in which the specific disasters we have just experienced will not occur, but in so doing we may forget the new hazards we may be creating, like the city which builds up a high pressure fire department after a big fire but pays little attention to the elimination of fire hazards, arsonists, and building fireproof buildings. We may meticulously prepare our blueprints but fail to see that for which we are building. Or we may make another approach—more modest,

less exciting, and less consoling for present anxieties about future years. In each area for which we wish to plan and reorganize, we can ask two questions, first, what are we learning, if anything, from the war? What is war compelling us to do and recognize? Are we suffering enough to make us think and explore for better paths? Second, what are we unlearning? What is war helping to emancipate us from—obsolete ideas, beliefs, practices, organizations? Are we learning to give up the compulsions that create disaster? In the field of health what are we learning and unlearning? It is difficult to see what is happening. Rarely does a society understand the nature of its contemporary problems. Only later generations see how irrelevant were most of the issues fought over and the unreality of the social problems debated. My personal conviction is we cannot *solve* social problems: they are the persistent tasks of life which face every generation. We can only reformulate these tasks, using new knowledge, techniques, resources, insights and try to find new goals and develop new sensibilities. . . . What are we learning about health agencies? What can we expect after the war—a continuation of the many separate government and private agencies for health? Are we learning during the war to recognize the multiplicity of agencies, budgets, staffs, the growing number of specialists? the variety of assumptions, practices, and goals? the fractionation of health programs, the innumerable divisions affecting family life? the lack of a national policy regarding the family as shown by different practices of the Selective Service; the income tax; the courts; the Public Health Service and its branches, the National Institute of

(Continued on page A11)

Summer Courses for Public Health Nurses

SUMMER COURSES IN UNIVERSITIES WHOSE PROGRAMS OF STUDY IN PUBLIC HEALTH NURSING HAVE BEEN APPROVED BY THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

California

Berkeley. University of California. June 28-August 28. Health teaching in nursing situations and other courses in economics, education, physiology, and psychology will be offered during the regular session. No institutes or special session courses will be given this year. For further information write to Margaret Tracy, director, School of Nursing, or dean of the summer session.

Colorado

Boulder. University of Colorado. June 18-August 27. Courses in principles of public health nursing, public health nursing special fields, teaching nursing and health. A course in public health nursing supervision will be open to advanced students under conditions described in the Announcement of the School of Nursing. Kathleen Leahy, assistant professor and director of public health nursing field work, University of Washington, will be the guest professor for the summer quarter.

For further information write to Henrietta M. Adams, director, School of Nursing.

District of Columbia

Washington. Catholic University of America. First session, June 28-August 7. Introduction to public health nursing, public health nursing services in maternal health and in orthopedic programs, public health nursing services in child health, organization and administration in public health nursing, public health nursing and adult health supervision, field of professional social work. Second session, August 9-September 18. Public health nursing services in infant and preschool health program, public health nursing services in the school health program, and public health nursing services in maternal health and orthopedic programs.

For further information write to Lucia M. Sweeton, director of public health nursing, School of Nursing Education.

Illinois

Chicago. Loyola University. June 25-July 30. Professional courses to be offered during the session toward the Certificate in Public Health Nursing and the Bachelor of Science in Public Health Nursing: principles of public health nursing, special fields in public health nursing, sociology, social case work, community hygiene and epidemiology, nutrition, public health administration, school health problems, and industrial nursing. The course in industrial nursing will be given by experts in the industrial nursing fields and will cover the subjects of program planning in industrial nursing, occupational diseases, first aid, safety and engineering, nutrition, and relationships in industry.

For further information write to Edna Lewis, director, Department of Public Health Nursing, Loyola University College, 28 North Franklin Street.

Chicago. The University of Chicago. Summer quarter, June 21-September 11. This year the summer quarter will be divided into four terms of three weeks each and course units are so arranged that students may complete two half-courses in three weeks; two courses in six weeks; or four courses in twelve weeks. Several courses will be offered as complete courses the first six weeks and will be repeated the second six weeks. Other courses will extend throughout the entire twelve weeks but may be taken as half-courses in six weeks. First term, June 21-July 10; second term, July 12-July 31; third term, August 2-August 21; fourth term, August 23-September 11. The following courses will be offered as complete courses during the first

SUMMER COURSES

and second terms and will be repeated during the third and fourth terms: principles of public health nursing and the teaching of health. The following courses extend through the four terms and may be entered only at the beginning of the first term: survey of the history of nursing, the construction and use of achievement tests in nursing, and public health. The following course extends through the four terms and may be entered at the beginning of the first and third terms: special fields in public health nursing. The following courses will be offered as complete courses during the first and second terms: supervision in public health nursing and evaluation of nursing procedures. The following courses will be offered as complete courses during the third and fourth terms: the curriculum in nursing education, teaching nursing in the clinical fields, and organization and administration in public health nursing. A limited number of tuitional scholarships are available to students in nursing education. Application should be made through the Nursing Education office well in advance of the opening of the summer quarter. A limited number of students from Nursing Education will be admitted to the summer workshops in the Department of Education. Information concerning the workshops will be found in the *Summer Workshops Announcements* which will be sent upon request.

For further information write to Nellie X. Hawkinson, Nursing Education Department.

Indiana

Bloomington. Indiana University. First session, May 3-June 23. Principles of public health nursing, advanced principles of public health nursing, principles and methods of teaching health, maternal and child care, field work with a nonofficial public health nursing agency, and field work with an official public health nursing agency. Second session, June 24-August 21. Principles of public health nursing, advanced principles of public health nursing, field work with a nonofficial public health nursing agency, and field work with an official public health nursing agency.

For further information write to Frances Orgain, assistant professor of nursing education, School of Education.

Massachusetts

Boston. Simmons College. June 28-August 6. Courses in principles of supervision, principles of teaching, nutrition for nurses, psychology for nurses, principles of public health nursing, public health nursing in schools, and social hygiene.

For further information write to Helen Wood, director, School of Nursing, 300 The Fenway.

Minnesota

Minneapolis. University of Minnesota. First session, June 14-July 23. Courses in public and personal health, health of the school child, principles of public health nursing, field practice in rural nursing, field practice with family health agency, introduction to health education, preventive medicine, public health administration and field work, environmental sanitation I, water supply sanitation, food sanitation, topics in public health, health education problems, conservation of hearing, principles and problems of teaching social hygiene, problems in public health nursing, workshop in public health nursing supervision, biometric principles, biostatistics laboratory, topics in biostatistics. Second session, July 26-August 27. Courses in tuberculosis and its control, mental hygiene, field practice in school nursing, field practice in rural nursing, field practice with family health agency, school nursing, special methods and supervised teaching in health education for public health nurses, nutrition for public health nurses, preventive medicine, and problems in public health nursing.

For further information write to Ruth B. Freeman, director, course in public health nursing, 121 Millard Hall.

Missouri

St. Louis. St. Louis University. First session, May 17-June 19. Special phases of public health nursing, and organization and administration of public health nursing. Second session, June 21-July 30. Principles of public health nursing, special phases of public health nursing, principles of teaching applied to public health nursing, social case work as applied to public health nursing. Third session, August 2-September 4. Special phases of public health nursing.

PUBLIC HEALTH NURSING

Institutes: June 1-June 30, industrial hygiene for nurses; July 1-July 30, public health nursing in venereal disease control.

For further information write to A. Louise Kinney, director, Division of Public Health Nursing, School of Nursing, 1325 South Grand Boulevard.

New Jersey

Newark. Seton Hall College. First session, June 28-July 16. Courses in principles of public health nursing, orientation to orthopedic nursing, dental health education, school nursing, mental hygiene, educational psychology, principles of sociology, and industrial hygiene for nurses. Field work in public health nursing to be arranged. Second session, July 19-August 6. Courses in special fields in public health nursing, administration in public health nursing, nutrition and health, methods in teaching home nursing, principles and methods of teaching, child growth and development, and problems in sociology.

For further information write to the School of Nursing Education, 72 Central Avenue.

New York

Brooklyn. St. John's University. Intercession, June 1-30. Courses in foundations in nursing education, school nursing, observation and student teaching, child psychology, public speaking, and field experience in public health nursing. Summer session, July 5-August 13. Courses in principles and methods in nursing education, principles and methods of supervision, public health nursing I-II, nutrition and health, psychology for teachers.

For further information write to Philomena Supper, director, School of Nursing Education, 96 Schermerhorn Street.

Buffalo. University of Buffalo. June 28-August 7. Courses in introduction to case work for nurses, principles of public health nursing I, teaching in public health nursing including practice teaching, seminar in family behavior. Also courses in English, sociology, psychology, educational psychology, child psychology. Because of an accelerated program the University is operating three sessions during the summer: May 24-June 26, June 28-August 7 (this is the regular summer session and the period during which the professional nursing courses will be available), and August 9-September 18. These sessions are so arranged that students may take instruction in one or all of them to a maximum of 21 semester hours of study.

For further information write to the director, School of Nursing, 25 Niagara Square.

New York. Columbia University, Teachers College. Intercession, May 24-June 11. Courses in rural sociology and teaching of home nursing. Summer session, July 6-August 13. Courses in supervision in public health nursing, teaching in public health nursing, survey of nursing history, public health nursing, school nursing, and public health administration. Also foundational courses in education including psychology, sociology, principles of teaching, philosophy of education; personnel and guidance courses; speech; applied biology and nutrition.

For further information write to General Information Office, Teachers College.

New York. New York University, Washington Square. Intercession, June 8-July 2. The administration of public health, guest instruction, Dr. Margaret W. Barnard, assistant commissioner of health, New York City Department of Health. Workshop in the clinic. First summer session, July 7-23. Courses in organization of school nursing, principles of public health nursing I, community problems and the nurse, teaching of home nursing and child care I, applied nutrition for health supervisors, applied microbiology for health supervisors, the living organism I, principles and methods of teaching in nursing education (guest instructor, Ruth B. Freeman, director, Public Health Nursing Curricula, University of Minnesota). Second summer session, July 26-August 13. Courses in organization of school nursing II, principles of public health nursing II, assisting the family with wartime adjustments, teaching of home nursing and child care II, applied nutrition for health supervisors, applied microbiology for health supervisors, introduction to supervision in public health nursing (Miss Freeman), the living organism II (biology and chemistry). August 16-27, industrial nursing. August 30-September 30, communicable diseases and the public health nurse. July 7-August 13, orthopedic courses at Lake Sebago; survey of physical defects in children, practicum in rehabilita-

SUMMER COURSES

tion of orthopedic defects, adaptation of physical education activities for the atypical individual. A special group of courses will be offered at Lake Sebago to meet the needs of nurses who are interested in the rehabilitation through the adaptation of recreational activities of the physically disabled. These courses are included in the workshop on rehabilitation through recreation. Some of the courses included in the workshop are: physiological aspects of recreational therapy, physical inspection, and foundations of a philosophy for American recreation. For further information write to Helen C. Manzer, School of Education.

Syracuse. Syracuse University. July 5-August 14. Courses in principles of public health nursing, case studies in public health nursing, methods of teaching in public health nursing, special fields in public health nursing, nursing in schools, public health and statistics, nutrition, sociology, education, and psychology.

For further information write to Ellen L. Buell, director, Department of Public Health Nursing, College of Medicine.

North Carolina

Chapel Hill. University of North Carolina. June 7-27. The public health nurse in a maternal health program. Guest instructor, Louise Zetsche, supervisor of maternal and infant welfare, Denver, Colorado.

For further information write to Margaret Blee, assistant professor of public health nursing, Department of Public Health Nursing, School of Public Health.

Ohio

Cleveland. Western Reserve University. June 21-August 6. Public health nursing I, supervision in public health nursing, orthopsychiatry, principles and methods of teaching in nursing, current trends in nursing, and curriculum in schools of nursing. Related courses in other departments of the University are offered.

For further information write to dean, School of Nursing, 2063 Adelbert Road.

Oregon

Portland. University of Oregon. June 21-September 4. Courses in principles and organization of public health nursing, field work in public health nursing, introduction to case work methods, community organization, assessment of physical fitness, and advanced public health.

For further information write to Elnora E. Thomson, director of nursing education, Medical School.

Pennsylvania

Pittsburgh. Duquesne University. Pre-summer session, June 1-28. Courses in health education and public health nursing I. Regular summer session, June 28-August 6. Public health nursing IV (school nursing).

For further information write to Mary W. Tobin, dean, School of Nursing.

Pittsburgh. University of Pittsburgh. June 1-September 20. Advanced practice in public health nursing. June 7-July 2. Courses in industrial nursing and community health problems. June 7-July 30. Courses in organization and administration of public health nursing and special problems in public health nursing. July 6-July 30. Courses in community nursing and school nursing.

For further information write to Dorothy Rood, chairman, Department of Public Health Nursing, School of Nursing.

Tennessee

Nashville. George Peabody College for Teachers. June 7-August 20. Courses in principles and organization of public health nursing, maternal, infant, and preschool health, communicable diseases, school nursing, principles of public health and sanitation, public health administration, health and nutrition, industrial nursing, supervision in public health nursing, administration in public health nursing, school health education, and public health workshop.

For further information write to Aurelia B. Potts, director, Division of Nursing Education.

PUBLIC HEALTH NURSING

Washington

Seattle. University of Washington. First session, June 16-July 23. Second session, July 26-August 27. Courses in special fields in public health nursing, epidemiology, methods of supervision in public health nursing, principles of teaching health, methods of hospital supervision, and social case work. Courses in allied fields of sociology, education, psychology, English, and public speaking will be offered. The University is planning to offer a two-weeks' intensive course in industrial nursing, the dates and instructors to be announced later.

For further information write to Elizabeth Soule, director, School of Nursing Education.

Wisconsin

Madison. University of Wisconsin. June 21-July 30. Courses in principles of public health nursing, teaching in public health nursing, and field work in public health nursing. Courses are also available in nutrition and psychology.

For further information write to Mrs. Pearl Coulter, associate professor of public health nursing.

Milwaukee. Marquette University. First session, May 24-July 2. Principles of public health nursing I and maternal and infant hygiene. Second session, July 5-August 14. Principles of public health nursing II, school health service, and principles and methods of teaching.

For further information write to Mary I. McCarthy, director, public health nursing, College of Nursing, 3058 North 51 Street.

OTHER COURSES IN CURRICULA WHICH HAVE NOT BEEN EVALUATED BY THE N. O. P. H. N.

New York

New York. The New York School of Social Work, Columbia University. June 22-September 3. Social case work, introduction to community organization, family economics, child welfare, industrial relations, and other related courses.

For further information write to the registrar, 122 East 22 Street.

Texas

San Antonio. Incarnate Word College. First session, June 4-July 15. Introduction to public health nursing, methods of learning health as related to public health nursing, and practice teaching in connection with course in methods of learning health. Second session, July 16-August 26. Public health nursing services—maternal and child health, adult health supervision, and principles of supervision in public health nursing.

For further information write to Alice M. Fay, director, program of study in public health nursing.

THE AMERICAN JOURNAL OF NURSING FOR APRIL

Gonorrheal Ophthalmia Neonatorum:

How the Sulfonamides Are Used..... I. Michael Levin, M.D., and Maurice L. Blatt, M.D.

Nursing Care..... Phyllis Mealy, R.N.

Dermatitis in Industry..... John G. Downing, M.D.

Food Rationing and the Diabetic..... Mary E. Tangney, R.N.

No Corner on Patriotism..... Margaret Tracy, R.N.

Nurses Work with Volunteers

A Merit Rating Scale..... Margaret E. Barnes, Ph.D., and Dorothy E. Chapman, R.N.

Social and Health Aspects of Nursing

NOTES from the NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

BOARD AND COMMITTEE MEMBERS SECTION

During coming months the Section will work closely with the Committee on Nursing Administration of the N.O.P.H.N. to promote an understanding among citizen groups of the need for organized nursing care of the sick in their homes in 16 communities throughout the country included in a recent survey. This was adopted as a special project of the Section when the Executive Committee met at the Henry Hudson Hotel in New York on March 10 and heard a report of the survey by Hortense Hilbert, associate director.

Members of the Executive Committee of the Section will study the detailed reports of each community and will make every effort to find local groups who will help develop essential, unified public health nursing service. The Section will then work closely with the local committees and help them in every way possible. The Section also plans to work with national women's organizations in promoting widespread understanding of the importance of essential public health nursing in wartime.

As a means of uniting public health nursing agencies in the country in one concerted publicity effort, the Section voted to promote a Public Health Nursing Day in 1944. The date was tentatively set for some time in March. The Executive Committee will welcome suggestions.

Members of the Section are also working to promote lay sustaining membership in the N.O.P.H.N. State lay representatives already at work are: Mrs. Frank G. Bosworth of Denver for Colorado; Mrs. Louis L. Coudert of Hartford

for Connecticut; Mrs. Gammell Cross of Providence for Rhode Island; Mrs. Saidie Orr Dunbar of Portland for Oregon; Mrs. R. Livingston Ireland of Cleveland for Ohio; Mrs. Eunice H. Leonard of Columbia for South Carolina; Isabel Noble of Wichita for Kansas; Mrs. Frank W. Penrose of Salt Lake City for Utah; Mrs. John Satterfield of Buffalo for northern New York State; Mrs. Dietrich Schmitz of Seattle for Washington; Mrs. George Springmeyer of Reno for Nevada; Mrs. S. Emlen Stokes of Moorestown for New Jersey; Mrs. Langdon T. Thaxter of Portland for Maine; Mrs. James K. Watkins of Grosse Pointe Farms for Michigan; and Mrs. William Wells of Washington for the District of Columbia.

ONE IN TEN

At its spring meeting the N.O.P.H.N. Executive Committee will consider ways and means of getting acceptance of the "one in ten" principle. This goes back to a letter sent in January to all state health officers in the country pointing out the already acute shortage of prepared public health nurses, and asking for their assistance in specific ways: (1) make public the need for prepared public health nurses for civilian protection (2) see that federal funds available for training public health nurses are used to their fullest extent, and (3) urge public health nurses on state staffs to recruit for the public health nursing fields some nurses from every good school of nursing in her area. Senior students very often are informed only about institutional and military services. *One out of every ten* graduates from schools of nursing entering the public health field would main-

PUBLIC HEALTH NURSING

tain our present professional numbers.

Point three has aroused widespread interest and member agencies as well as health officers and other deeply concerned individuals are pressing for immediate action.

IN THE FIELD

SKIDMORE COLLEGE, DEPARTMENT OF NURSING, Saratoga Springs and New York, N. Y., February 22 to March 6—Mary C. Connor, N.O.P.H.N., and Clara Quereau, N.L.N.E., made a joint accreditation visit to Skidmore. This was the first visit of its kind—the initial step taken in accordance with the recommendations of the three Boards of the N.L.N.E., the A.C.S.N., and the N.O.P.H.N., in the interests of coordinating their accrediting activities in nursing. The A.C.S.N. did not visit in this instance as Skidmore has been a member of the A.C.S.N. for some time.

Bethesda, Md., March 1-10.—Mrs. Bethel McGrath attended the industrial nursing institute given under the auspices of the Industrial Hygiene Division of the U. S. Public Health Service.

NEW JERSEY STATE TEACHERS COLLEGE, Newark, March 4.—Jessie L. Stevenson spoke on posture to a teacher group at an evening meeting, showing Kodachrome slides on posture in nursing activities.

AMERICAN RED CROSS, Washington, D. C., March 5—Ruth Houlton attended a meeting of the A.R.C. Nursing Advisory Committee. At this meeting, discussion brought out the fact that Miss Beard's letter to Dr. Parran stating that public health nurses with few exceptions are placed by the Red Cross in a deferred classification has been sent out to all state health officers. See page 179.

HARVARD MEDICAL SCHOOL, Boston, March 8-10—Miss Stevenson gave advisory service to N.O.P.H.N. scholarship students taking the physical therapy

course. She also spoke to the physical therapy group at Harvard on opportunities for public health nurses with physical therapy training and ways in which nursing and physical therapy services might be correlated.

SIMMONS COLLEGE, SCHOOL OF NURSING, Boston—Miss Stevenson conferred with Marjory Stimson and other members of the faculty concerning ways in which Simmons plans to incorporate the orthopedic unit of The Public Health Nursing Curriculum Guide in its program of study.

COMMUNITY HEALTH ASSOCIATION, Boston—While in Boston, Miss Stevenson conferred with Dorothy Carter, Elizabeth Howland, and Mary M. Macdonald concerning ways in which orthopedic nursing could be integrated in clinical experience for students.

THE PROVIDENCE DISTRICT NURSING ASSOCIATION, Providence, R. I., March 11—Miss Stevenson gave a day's advisory service on orthopedic nursing. As a result of her conferences with the directors of the D.N.A. and the V.N.A. of Pawtucket, these agencies agreed to exchange the services of specialists on their staffs. The Providence nutritionist will be shared with the Pawtucket V.N.A. and in return, the orthopedic consultant of the Pawtucket agency will spend time with the Providence agency.

THE VISITING NURSE SOCIETY OF PHILADELPHIA, March 12—Miss Stevenson attended a Nursing Committee meeting regarding the initiation and planning of their orthopedic program. On March 25, Mary C. Connor visited the V.N.S. to confer with Ruth Hubbard, chairman of the N.O.P.H.N. Committee on Accreditation.

Fall River, Boston, Springfield, and Worcester, Mass., March 15-29—Margaret S. Arey conducted a series of orthopedic institutes sponsored by the State

N.O.P.H.N. NOTES

Department of Health for nurses from hospitals and schools of nursing and local nonofficial public health nursing agencies. This was followed by a conference with the state supervisory nurses. Miss Arey demonstrated the Kenny Method of packs and muscle re-education.

DISTRICT NURSING ASSOCIATION OF PORTLAND, Maine, March 16—Ruth Fisher attended an institute for lay members of Portland and vicinity. **VISITING**

NURSE ASSOCIATION OF PAWTUCKET AND CENTRAL FALLS, R. I., March 18—Miss Fisher gave a day's advisory service to this agency.

THE PUBLIC HEALTH NURSING ASSOCIATION OF PITTSBURGH, March 23—Hortense Hilbert spoke at the annual luncheon meeting on the responsibility of the public health nursing associations for the care of mothers and children in relation to wartime.

HONOR ROLL

"Membership is a badge of honor for individual and agency alike."

EMILIE SARGENT

NATIONAL MEMBERSHIP CHAIRMAN

Congratulations to the 170 agencies on this first list of 1943 Honor Roll agencies. Many more agencies are eligible, we are sure, but have failed to notify the N.O.P.H.N. Do let us know at once if your staff is 100 percent enrolled as N.O.P.H.N. members so that we may include your agency in the next published list.

The Honor Roll list is not cumulative during the year but each month we will publish the names of those agencies—whether they have one nurse or 100—who write us that all their nurses are enrolled in the N.O.P.H.N. for 1943.

ALABAMA

- *Birmingham—Metropolitan Life Insurance Nursing Service
- *Fayette—County Health Department
- Montgomery—Metropolitan Life Insurance Nursing Service

ARIZONA

- *Chandler—Public School Nursing Service
- *Miami—Public Schools

ARKANSAS

- Forrest City—St. Francis County Health Unit

COLORADO

- Denver—Health Service Department, Public Schools

- *Denver—Metropolitan Life Insurance Nursing Service

- *Denver—Visiting Nurse Association

CONNECTICUT

- Bristol—Bristol Visiting Nurse Association
- *Middletown—District Nurse Association
- Norwalk—Health Department
- *Waterbury—Visiting Nurse Association

DISTRICT OF COLUMBIA

- *Washington—Kiwanis Club Clinic for Crippled Children

GEORGIA

- Mount Vernon—Montgomery County Public Health Service
- *Savannah—Health Center
- *Savannah—Sugar Refining Corporation

ILLINOIS

- *Bloomington—Metropolitan Life Insurance Nursing Service
- *Chicago—Goodman Manufacturing Company
- East Moline—Nursing Service
- *Evanston—Infant Welfare Society
- Lawrenceville—Lawrence County Health Department
- Monmouth—City Schools
- Naperville—Health Department
- *Quincy—Adams County Tuberculosis League
- *Rockford—Visiting Nurse Association

*Agencies which have been on the Honor Roll for five years or more.

PUBLIC HEALTH NURSING

INDIANA

- *Kokomo—Metropolitan Life Insurance Nursing Service
- Logansport—Metropolitan Life Insurance Nursing Service
- *Muncie—Delaware County Tuberculosis Association
- Terre Haute—Vigo County Nursing Service

IOWA

- Burlington—Metropolitan Life Insurance Nursing Service
- Carroll—Carroll County Nursing Service
- *Council Bluffs—Visiting Nurse Association
- Decorah—District Health Office No. 1
- *Keokuk—Public Schools
- *Mason City—Mason City School Nursing Service
- Ottumwa—Metropolitan Life Insurance Nursing Service
- Pocahontas—Pocahontas County Public Health Nursing Association
- *Primghar—O'Brien County Nursing Service
- *Waterloo—Black Hawk County Nursing Service

KANSAS

- Kingman—Kingman County Red Cross Nursing Service
- *Salina—Public Health Nursing Association

KENTUCKY

- *Henderson—Metropolitan Life Insurance Nursing Service
- *Madisonville—Metropolitan Life Insurance Nursing Service
- Newport—Metropolitan Life Insurance Nursing Service
- *Owensboro—Metropolitan Life Insurance Nursing Service

LOUISIANA

- Lake Charles—Calcasieu Parish Health Unit
- Shreveport—Caddo-Shreveport Health Unit

MAINE

- *Bath—Bath Chapter, American Red Cross
- *Ellsworth—Hancock County Health Service
- *Northeast Harbor—Mount Desert Chapter, American Red Cross
- *Wilton—South Franklin County Nursing Service

MARYLAND

- *Cambridge—Dorchester County Health Department
- *Frederick—The Federated Charities

MASSACHUSETTS

- *Dedham—Emergency Nursing Association
- *Fitchburg—Visiting Nurse Association
- *Great Barrington—Visiting Nurse Association

- *Holyoke—Visiting Nurse Association, Inc.
- *Hyannis—District Nursing Association of Barnstable, Yarmouth, and Dennis
- *Lowell—Visiting Nurse Association
- *New Bedford—Instructive Nursing Association
- *Pittsfield—Berkshire County Tuberculosis Association
- *Waltham—District Nursing Association
- *Watertown—District Nursing Association

MICHIGAN

- *Bay City—Public Health Nursing Service of the Civic League
- *Grand Haven—Ottawa County Health Department
- *Grand Rapids—Kent County Health Department
- *Grand Rapids—Community Health Service
- Kalamazoo—Metropolitan Life Insurance Nursing Service
- *Saginaw—Visiting Nurse Association

MINNESOTA

- Alexandria—Public Schools
- Aurora—Public School Health Department
- Battle Lake—Ottertail County Sanatorium
- Bemidji—Teachers College
- Benson—Swift County Public Health Nursing Service
- Brainerd—Crow Wing County Public Health Nursing Service
- Caledonia—Houston County Nursing Service
- Cass Lake—Cass County Indian Service, Minnesota Department of Health
- *Duluth—City Health Department
- Gaylord—Sibley County Public Health Nursing Committee
- Hutchinson—Hutchinson School Nursing Service, Board of Education
- International Falls—Koochiching County Nursing Service
- Lake Park—Sand Beach Sanatorium
- Litchfield—Meeker County Nursing Service
- Long Prairie—Todd County Nursing Service
- Mankato—School Nursing Service
- Minneapolis—Department of Preventive Medicine and Public Health, University of Minnesota
- *Minneapolis—Hennepin County Rural Public Health Nursing Service
- Minneapolis—Medical Unit, Post Office
- Minneapolis—Industrial Nurse Service—Sears Roebuck Company
- Minneapolis—Industrial Nurse Service—Street Railway Company
- Moorhead—Public Schools
- Mound—School Nursing Service

N.O.P.H.N. NOTES

Nashauk—School Nursing Service
 Onamia—United States Indian Service
 Owatonna—School Nursing Service
 Red Wing—Goodhue County Nursing Service
 St. Cloud—Teachers College Nursing Service
 *St. Paul—Bureau for Crippled Children, Division of Social Welfare, Department of Institutions
 Thief River Falls—Pennington County Nursing Service
 Tracy—School Nursing Service
 Two Harbors—School Nursing Service
 Wabasha—Buena Vista Sanatorium
 Willmar—Kandiyohi County Nursing Service

MISSOURI

*Clayton—St. Louis County Metropolitan Life Insurance Nursing Service
 Fulton—Callaway County Nursing Service
 Marshfield—Webster County Public Health Nursing Service
 Pineville—McDonald County Public Health Nursing Unit
 *St. Louis—Board of Education—Hygiene Division
 *St. Louis—Municipal Visiting Nurses
 *St. Louis—Visiting Nurse Association

MONTANA

*Helena—Division of Crippled Children—State Board of Health

NEBRASKA

Omaha—Public Schools

NEW HAMPSHIRE

*Concord—District Nursing Association
 *Lancaster—Chapter, American Red Cross

NEW JERSEY

*Asbury Park—Metropolitan Life Insurance Nursing Service
 *Bayonne—Visiting Nurse Association
 Bordentown—Visiting Nurse Association, Inc.
 *Hackensack—Central Bergen Visiting Nurse Service
 Nutley—American Red Cross Public Health Nursing Service
 *Ramsey—Northern Bergen Nursing Service
 *Somerville—Somerset County Tuberculosis and Health Association

NEW MEXICO

*Fort Sumner—DeBaca County Health Department

NEW YORK

Bronxville—Public Schools
 *Hempstead—John Hancock Mutual Life Insurance Nursing Service
 *Hempstead—Metropolitan Eastern Long Island Nursing Service

*Kingston—Metropolitan Life Insurance Nursing Service
 Lockport—Metropolitan Life Insurance Nursing Service
 *New York—National Organization for Public Health Nursing
 *New York—National Society for the Prevention of Blindness
 Nyack—Metropolitan Life Insurance Nursing Service
 *Watertown—Metropolitan Life Insurance Nursing Service

NORTH CAROLINA

*Burlington—Metropolitan Life Insurance Nursing Service
 *Durham—Metropolitan Life Insurance Nursing Service
 Fayetteville—Health Department of Fayetteville and Cumberland County
 *High Point—City Health Department
 *High Point—Metropolitan Life Insurance Nursing Service

OHIO

*Cleveland—Visiting Nurse Association
 *Sandusky—Metropolitan Life Insurance Nursing Service
 *Steubenville—Metropolitan Life Insurance Nursing Service
 *Toledo—Toledo District Nurse Association

OKLAHOMA

*Tulsa—Public Health Association

OREGON

Baker—Baker County Health Department

PENNSYLVANIA

*Lansdale—Community Service
 McKees Rocks—Public Health Nursing Association
 Meadville—Metropolitan Life Insurance Nursing Service
 *Philadelphia—Visiting Nurse Society—North Branch
 *Philadelphia—Visiting Nurse Society—Manayunk Branch
 *Pottstown—Visiting Nurse Society
 *Reading—Visiting Nurse Association
 *Scranton—Visiting Nurse Association

RHODE ISLAND

*Cranston—School Health Division
 *Pascoag—Burrillville District Nursing Association
 Providence—Department of Health and Physical Education—Department of Public Schools

(Continued on page A12)

Reviews and Book Notes

LET'S MAKE A STUDY—I AND II

Prepared by Community Chests and Councils, Inc.
Bulletin 114-a, 53 pp.; Bulletin 114-b, 48 pp. Chests
and Councils, 155 East 44 Street, New York, 1942.
\$1 each; \$1.50 for both.

The title of Part I of this publication is the least formidable aspect of the 53-page pamphlet. Among the good points is the emphasis on different approaches to studies—such as the use of statistical data, of case analysis, and of comparison with accepted standards. Technical knowledge of problems involved is recognized as an important prerequisite for the persons conducting and carrying through to action the studies made under the auspices of the Community Chests and Councils. Chapter V, Shaping Plans for Action, is helpful with its stress on recognizing what kinds of actions are likely to result before undertaking a study.

There are several adverse considerations one may make after paging through the pamphlet. In places the terminology is awkward. Unnecessarily long sentences make difficult reading. Nothing new is offered in statistical method. The suggestions under statistics concern counts rather than relationships. A table on page 45 indicates that the cost of research in 32 cities averaged 78 cents per 100 inhabitants. In the text on this page is the statement that less than one cent per capita was used for research. To many readers this will be confusing.

For the director of a public health nursing agency, this bulletin will add little to her understanding of research in the Community Chest or in her own agency.

Part II contains statistical aids. Four sources of figures for comparisons in the

health field are given—two from the U. S. Children's Bureau; one, the Appraisal Form of the American Public Health Association; and the fourth, Volumes 13, 14, and 15 of the U. S. Census. The figures for the items to be compared in a given area are given as average figures, some for the United States and some from the Children's Bureau "Community Welfare Picture in 34 Urban Areas." The Children's Bureau guarded their averages by explanations. This bulletin selects certain averages with little explanation of what is included or of how satisfactory the average is as a measure. A twisting of figures on page 35 concerning expenditures in public and private hospitals is unfortunate.

This bulletin has something to offer one interested in studying the health of a community, if the material is critically used and not accepted without reviewing the sources given.

D. E. W.

PUBLIC HEALTH STATISTICS

By Marguerite F. Hall, Ph.D. 408 pp. Paul B. Hoeber, Inc., New York, 1942. \$5.50.

In this book public health figures and statistical procedures are presented as related topics. Measures of dispersion, of central tendency, and of reliability are couched in terms of the public health worker. The chapters on the construction and the use of tables, charts, and graphs, should be of value for both the presentation and the interpretation of statistical material. The warnings on the pitfalls of statistical procedures, such as errors in collection, comparisons of incomparable data, misinterpretation of findings, are well pointed out. The explanation of the construction of life

BOOK NOTES

tables is particularly clear. It is well indexed and has good illustrations.

The value of machine methods for statistical procedures is clearly demonstrated, but their limitations are not pointed out. No mention is made of some of the punch-card methods that depend on hand- rather than machine-sorting. For many health services such methods would be of value where the expense of the more elaborate machine setup cannot be justified. One wonders

why quite so much emphasis is put on the use of the probable error when there is a growing preference among statisticians for the standard error. However, these constitute only minor criticisms.

This book should be of great value to public health workers as a stimulating introduction for the novice and as a quick, convenient reference for the expert.

MARION FERGUSON, R.N.
Chicago, Illinois

RECENT PUBLICATIONS AND CURRENT PERIODICALS

WARTIME

GUIDES TO SUCCESSFUL EMPLOYMENT OF NON-FARM YOUTH IN WARTIME AGRICULTURE. U. S. Children's Bureau Publication No. 290. Available from the Bureau, Washington, D. C., 1943. 14 pp.

Prepared by the Children's Bureau, U. S. Department of Labor, in consultation with the U. S. Department of Agriculture, Office of Civilian Defense, Office of Education, War Manpower Commission, and approved by these agencies.

SOUND EDUCATIONAL CREDIT FOR MILITARY EXPERIENCE. Prepared and distributed by the American Council on Education, 744 Jackson Place, Washington, D. C., 1943. 35 pp.

TWO PAMPHLETS compiled by the Women's Bureau, U. S. Department of Labor, 1943.

Boarding Homes for Women War Workers. Special Bulletin No. 11. (Free from Bureau.)

Wartime Reminders to Women Who Work. Superintendent of Documents, Washington, D. C. 8 pp. 5c.

WARTIME INDUSTRIAL HEALTH. Reprinted from *California and Western Medicine*, October 1942. Available from the offices of the magazine, 450 Sutter Street, San Francisco, California. 12 pp.

A symposium of addresses—in full or in abstract—given at Institutes on Wartime Industrial Health held in several California cities on August 18-28, 1942. These were sponsored by

the California State Board of Public Health, the California Medical Association, and the Western Association of Industrial Physicians and Surgeons.

WHAT THE SCHOOLS SHOULD TEACH IN WARTIME. Available from the Educational Policies Commission, 1201 Sixteenth Street, N.W., Washington, D. C., 1943. 10c.

YOU AND THE WAR. Prepared by the U. S. Office of Civilian Defense. Available from local defense councils, 1942. 30 pp. Free.

MENTAL HYGIENE

PSYCHOLOGIC CARE DURING INFANCY AND CHILDHOOD. Ruth Morris Bakwin, M.D., and Harry Bakwin, M.D. D. Appleton-Century Company, Inc., New York, 1942. 317 pp. \$3.50.

PSYCHOTHERAPY IN MEDICAL PRACTICE. Maurice Levine, M.D. The Macmillan Company, New York, 1942. 320 pp. \$3.50.

"THE PHYSICIAN'S STATUS IN CHILD-GUIDANCE WORK." Philip Solomon, M.D. *The New England Journal of Medicine*, 8 Fenway, Boston, September 17, 1942, p. 427. Single copy 25c.

THREE PAMPHLETS prepared by the Military Mobilization Committee of the American Psychiatric Association. Reprinted by and available from the New York State Department of Mental Hygiene, Albany. Free.

Anxiety and Its Control.
Morale and Its Control.
Fatigue and Its Control.

NEWS

National Nursing Council for War Service

COUNCIL plans for state conferences and institutes to assist in problems of accelerating basic nursing curricula are developing rapidly under the direction of Helen G. Schwarz, with volunteer assistance from many able people in the field. In general, the conferences will include: (1) discussion of present requirements for state registration (2) going plans for acceleration (3) problems relating to basic program adjustments such as admission requirements, schedules, education facilities, and so forth. In addition to conferences, group discussion will be arranged if desired on getting supplementary experience for nurses ineligible for military service because of deficiencies in basic nursing preparation. Anna D. Wolf, director of nursing at Johns Hopkins, is chairman of the Committee on Field Service.

A new council bulletin on student recruitment, intended as a guide for state and local nursing councils, is just off the press. The bulletin states, "Government authorities say the 65,000 figure must be reached if military needs in the years ahead and even minimum requirements on the home front are to be met. . . . Much of the effort to inform the public and dramatize nursing must be made *this spring*." A tremendous effort is planned for the last of April and the month of May to persuade 65,000 qualified young women to enter schools of nursing in 1943-44. The campaign is being pushed by the Office of War Information at the request of the National Nursing Council and the Subcommittee on Nursing. The American Hospital Association is also cooperating in

plans for emphasizing student nurse recruitment during May. Thousands of retail stores throughout the nation will feature nursing by window displays, store booths, and in advertising. The O.W.I. is furnishing a new poster with the slogan, "Save his life and find your own." Leaflets will be available for local use. A national radio campaign is being planned. Public libraries will be asked to have exhibits. The Bulletin shows how nursing agencies can help put this campaign over with a hundred practical suggestions, in the conviction that "the best recruitment work is done right in the community by the nurses there." If your local council does not have a copy of Recruitment Bulletin 30, write the N.N.C.W.S.

FOUR new Corporation members-at-large of the N.N.C.W.S. were announced at the March Board meeting: Mrs. Chester C. Bolton, congresswoman from Ohio, for many years active in public health nursing and nursing education; Mrs. Ruth Logan Roberts, whose father was associated with Booker T. Washington in the founding of Tuskegee and who has herself made outstanding contributions in the field of race relations; Katharine Tucker, director of nursing education at Pennsylvania University and formerly general director of N.O.P.H.N.; and Dr. William P. Shepard, well-known public health physician on the West Coast. Mrs. Mabel K. Staupers has replaced Mrs. Marion B. Seymour, representing the N.A.C.G.N. on the Board.

Rapid growth is a common characteristic of the community health aide pro-

NEWS NOTES

grams inaugurated simultaneously in several parts of the country to provide high school girls with opportunities for community war service. Original action has been taken by hospital administrators, school nurses, and high school teachers. Training and local supervision are provided by nurses and home economics teachers. In one state the health and education departments have assumed joint responsibility for over-all direction of the program, and school credit is given the participants. Realizing that the program offers, besides community service and a stimulus to personal health, an opportunity to measure interest and aptitudes of individual students and that here is a fertile field for student recruitment, the Joint Committee of the Council and the American Hospital Association has voted its approval in principle. The Council will promote correlation of community aide activities with nursing programs through state and local nursing councils.

The Council has recommended the formation at headquarters of a War Cabinet comprising the executive directors of the N.O.P.H.N., A.N.A., N.L.N.E., N.N.C.W.S., the secretary of the N.A.C.G.N., the editors of the *American Journal of Nursing* and of *PUBLIC HEALTH NURSING*. The group it was hoped would meet regularly and frequently to provide

full clearance of wartime nursing information at headquarters, a mechanics for quick intercommunication, and discussion within the professional agencies, as well as follow-up of action taken by the Council.

THE Council has formed a new committee to collect and prepare information needed for support of the proposed Nurses Supply and Distribution Unit if and when congressional hearings are held. The members are: Mrs. Alma H. Scott, chairman, Alma C. Haupt, Pearl McIver, Ernestine Wiedenbach, Marian G. Randall, and Blanche Pfefferkorn.

To help meet shortages in medical care a special subcommittee of the Committee on Supply and Distribution is developing a series of guiding principles for the use of health agencies, physicians, and nurses. The additional responsibilities which nurses are carrying, not only in emergency areas but in every community, and such problems as the lack of bedside care for the sick in their homes, have pointed the need for a statement of principles which might strengthen programs of action under way in local communities. The N.O.P.H.N. has been giving intensive study to many of the problems involved. Katharine Tucker is chairman of the Committee on Supply and Distribution.

From Far and Near

- A two weeks' institute in public health economics for training in the organization and management of prepayment plans of various types will open May 10, 1943, at the School of Public Health, Ann Arbor, Michigan.

The Institute is designed to meet the needs of: (1) those already working with a prepayment plan or having a specialized interest in this field of administra-

tion and (2) those who are concerned with public health, hospital administration, or other community services and who feel it wise to learn about the growing field of health service plans. The instructing staff will include well-known authorities concerned with prepayment plans and with related problems of industry, labor, governmental, and professional bodies. Write Dr. Nathan Sinai,

PUBLIC HEALTH NURSING

The School of Public Health, University of Michigan, for further information.

- The Washington State Personnel Board announces a merit examination for the positions of public health nurse in the State Department of Health and county health departments at a salary range of \$145 to \$170. Applications will be accepted until further notice. Application forms may be obtained from the Board, 1209 Smith Tower, Seattle.

Tuberculosis Quizzes—To find out what the public knows and thinks about important health subjects, a series of information tests have been conducted in recent years, some details of which especially concerning tuberculosis are published in *Bulletin of the National Tuberculosis Association*, October 1942. The author, Dr. H. F. Kilander, tested 11,000 individuals of fairly high educational level; the U. S. Public Health Service, 100,000 people at the World's Fair in New York and the San Francisco Fair; the Gallup Poll also contributes some data. The average proportion of correct answers to four questions on tuberculosis in the Kilander test was 43, which score was considerably below the 62 percent average obtained by the complete test of 100 questions. The combined World's Fair responses to tuberculosis questions were 56 percent correct. This figure is the lowest for the nine separate health tests given on such subjects as nutrition, heart disease, and others. As to whether tuberculosis is inherited, 46 percent thought "yes." The Gallup Poll got 53 percent wrong replies to the same question. In a 1936 test, 45 percent indicated that children get tuberculosis by drinking milk from infected cows, while 30 percent considered contact with infected adults the most important source. By 1941-42, the figures had become 25 and 50 percent respectively, pointing at public health information progress. Some progress is also shown in public information relative to treatment procedures. In 1936, 43 percent stated that rest is most important, and 50 percent in the same test that dry climate is. In 1941-42 there was considerable improvement in replies to this question. The tests indicated considerable confusion in the public mind relative to inheritance and communicability, treatment and diagnosis, and the purpose of X-ray in tuberculosis, the meaning of tuberculin testing. Comparisons by educational levels seemed to indicate that edu-

cation *per se* does not necessarily add to health knowledge, unless training in health subjects has been included. None of the health tests indicated significant sex differences in information. Answers in the East were remarkably similar to those in the West except for two questions. In the West 95 percent as compared with 86 percent in the East associated tuberculin testing with milk cows and not with beef cattle or sheep. In the East 38 percent seemed to know that dry climate is not associated with tuberculosis treatment as against 18 percent in the West. The author concludes that many individuals and groups are still misinformed on certain aspects of tuberculosis, and that educational efforts by schools and colleges and public health agencies must ever continue to increase public enlightenment.

Maternity Service—The year 1942 was the busiest year for delivery service since 1929, according to the Annual Service Report of the Visiting Nurse Association of Detroit, Michigan. In 1941 there were 1,003 delivery patients and 1,184 delivery visits. In 1942 there were 1,263 delivery patients and 1,516 delivery visits. This is an increase of 260 patients and 332 visits. The increase in home delivery service is directly related to the increase both in the birth rate and population in Detroit, with approximately the same hospital facilities for obstetrical patients. Even though a previous plan had been made many patients have been unable to enter the hospital for delivery, and as a result there has been a tremendous increase in the number of nonregistered patients in our service. This always makes the delivery nurse's work more arduous since no supplies are ready and the patient and family require even more consideration than usual, since they are upset and apprehensive. In 1941 there were 621 nonregistered patients (almost half) out of a total of 1,263.

National Health Education Program—February 5 saw launched by the Chamber of Commerce of the United States under the direction of a National Health Advisory Council, a broad program looking to health conservation as a major factor in winning the war. Locally the program will be carried on through industrial organizations, chambers of commerce, and communities. Its object will be to reduce work absence, raise the morale and increase the physical effectiveness of workers, and to assist their families in problems of health, diet, illness, and nursing. The Advisory Council composed of

NEWS NOTES

some 30 distinguished leaders in medicine, public health, industrial and civilian life will serve to channel approved technical health information to business organizations and their members throughout the country. It will work through the U. S. Chamber of Commerce as a central organization, which, in turn, will work through its farflung membership of trade associations, chambers of commerce, and business concerns. Three committees of the Council—Community, Industrial, and Individual—have met to outline the first aims of the program. Marion G. Howell, president, N.O.P.H.N. and, incidentally, the only woman on the Council, is a member of the Individual Committee. A 5-point program starts off the campaign: (1) a regular publication for the average worker and family (2) "Keep Fit" posters (3) newspaper releases (4) personal and radio talks (5) Community, Industrial, and Individual Health Bulletin (program suggestions). Public health nurses will find effective health education materials, bulletins, and charts available free from local chambers of commerce, and other business and industrial groups affiliated with the U. S. Chamber.

Life Expectancy Increases—Between 1930 and 1940 the expectation of life at birth for the total population in the United States increased from 59.0 to 63.3 years, or 7 percent, according to a recent report from the U. S. Public Health Service. The relative increase was nearly twice as great for nonwhites as for whites. The expectation of life at birth increased 3.5 and 4.3 years for white males and females but 4.4 and 5.7 years for Negro males and females. However, the life expectancy for white persons is still appreciably greater than that for nonwhite persons. The expectation of life at birth is 63 years for white males and 67 years for white females, compared with 52 years for Negro males and 55 years for Negro females. After adjustment for changes in age distribution the death rate from all causes in 1939-40 was about 12 percent lower than the rate in 1929-31 for whites and about 20 percent lower for Negroes. The largest relative decreases occurred in the death rates of children and young adults but significant decreases were recorded throughout the entire life span even among persons in the older age groups. With the exception of the death rates from heart disease, cancer, and diabetes, the mortality rate for each of the important causes of death was lower in 1939 than in 1930. For the first time in the history of the registration area, the maternal mortality

rate declined uninterruptedly throughout the entire decade. The relative decrease was 48 percent among white mothers and 34 percent among nonwhite mothers. By the end of the decade the mortality of white infants had dropped to 4 percent and that of nonwhite infants to 7 percent. Read "Changes in Mortality Rates, 1930 to 1940" by H. F. Dorn in *Public Health Reports*, December 4, 1942.

National War Fund, Inc.—Important to every national and local health and welfare agency with a war-related program is the establishment of the National War Fund, approved by President Roosevelt and leading organizations such as U. S. O., community chests and councils, and major foreign relief groups. This project has developed out of nationwide demand for unified, local campaigns as evidenced by the experience of 500 city, county, and state war chests already in existence. Recommended by the President's War Relief Control Board, the Fund was created and publicly announced in January to raise funds to meet the reasonable requirements of all approved war-related appeals by working with existing local chests and war funds and stimulating similar campaigns in unorganized sections of the country; to distribute the funds to war appeal agencies; and to relate the various programs to international, national, and local needs. A Budget Committee will review requests for inclusion in the Fund, and recommend the amount to be raised in the 1943 fall campaign. A Quota Committee will carry on the study of state and local apportionment of funds raised. While state and local agencies reserve the right to distribute funds as they like, they will be strongly urged to follow recommendations of Budget and Quota Committees in order to preserve effective operation of national plan. A national program of publicity will back up local fall campaigns.

Birth Rates, 1942—In a recent address Dr. Louis I. Dublin, chief statistician of the Metropolitan Life Insurance Company, commented on the trend in the United States birth rate for the last hundred years and forecasted its immediate future. The following excerpt has a relation to public health nursing agency planning for maternity and infant services: *

"The recent rise in the birth rate in the United States is altogether a war phenomenon and is temporary in nature. The figure for 1942, namely 21 births per thousand population [at

(Continued on page 45)



Your Contribution to Young America

PUBLIC HEALTH NURSES are doing a big war service right here at home by teaching mothers to give Young America the right start in life.

As an aid to your public spirited service, we are offering you *free* a series of illustrated lessons and charts, also consumer folders in quantity for distribution to your groups on

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A8

In responding to an advertisement say you saw it in Public Health Nursing

News

(Continued from page 235)

least 2,800,000 births estimated], is higher than for any other year since 1925. It is a direct consequence of the rapid rise in marriages of young men before going into the armed forces of the country and is also a reflex of the substantial increase in employment at high wages.

"The current birth rate has probably reached a maximum in the present wave which began to move upward after 1933 when the figure was only 16.6 per 1,000 of population. At that time, the number of births reflected a family size barely sufficient to maintain the population at a stationary level. The increase during the last nine years has greatly improved that situation and the net reproduction rate is now very substantially above that required to keep the population stationary. But the continued participation of the country in the war effort will inevitably result in materially lower birth rates, perhaps to figures even lower than that of the minimum of 1933. Such declines have been the uniform experience of other countries at war, both in World War I and in World War II."

Youth Employment Policy—With youth between 14 and 18 years going into wartime employment the War Manpower Commission officially recognizes in a statement issued January 30 the necessity of protecting their health and welfare at work while at the same time using and developing their aptitudes, abilities, and interests. To this end the W.M.C. presents a 10-point basic national policy, a summary of which is:

1. School attendance laws and child labor standards must be preserved and enforced.
2. No one under 14 years should be employed full or part time as part of a hired labor force.
3. Youth under 18 should be employed only if employer obtains proof of age, and only if placed in work suited to age and strength under conditions conducive to health and safety, with hours not longer than 8 hours a day or 6 days a week. Certain exceptions are made in case of continuing farm work where worker lives at job, or in case of temporary special emergency. Wages equal to those of adult workers for the same work should be paid.
4. Youth of 14 and 15 are to be employed only when older workers are not available, and not at all in manufacturing or mining.
5. School attendance and work combined should not exceed 8 hours a day, at least for those under 16.
6. Only in a labor shortage emergency are school youth to be employed during school hours, and school programs are to be arranged so that such youth can still go on with their studies.
7. When emergency arrangements for employ-

PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

The Satisfactions of Obstetric Nursing in a Topsy-Turvy World

WHAT WOULD happen if the women in this country refused to have children? What would happen if women were forced to have children at certain times, and if the fathers of their children were chosen by the State? What would happen to our nation if we had too few children in the next generation to carry on our national life? Any serious contemplation of these questions makes good obstetric care take on new meaning to all of us. While we have been preparing for the possibility of bombs falling and spreading destruction, we have been awakening to the fact that we could make better preparation in some communities for the arrival of one of our most valuable possessions—a new baby.

The public health nurse who is helping to care for our civilian population is one of those people in the community who are thoroughly aroused to the need for improvement in the distribution and quality and quantity of the care that we are giving our young mothers. The nurse realizes that next to the physician she is the only person in her community with any professional obstetric training whatever, and people look to her for advice and for instructions as to what to do and how to do it. Besides giving what advice she can, the public health nurse must evaluate her own job and see if she is prepared to carry a full share of essential service for patients.

In urban communities, the supply of

medical and nursing service is still fairly adequate. In other communities the shortage of hospital beds and the pressure of work on the few remaining physicians is acute. In the past, too many doctors, nurses and lay people have been unwilling to explore the possibility of using in an organized way a public health nurse, specially trained in obstetrics, as a nurse-midwife. If we had such trained personnel in this country now, we would not be struggling with the full impact of the heavy load of maternity work.

We have never had enough doctors and nurses to give all patients adequate obstetric care. During the depression, studies show that at least one third of the women who were bearing children were not receiving safe care. Some folks said, "These people are on relief; they should not be having babies if they can not afford to pay to bring them into the world properly and support them after they get here." We are hearing very little of that sort of thing now. As a nation we are thankful for every able-bodied man and woman who can help with the war effort and for every healthy child who is born and lives.

The young public health nurse with obstetric training is torn between two desires—either to join the armed forces or to serve in the community where she is really needed and where she can best use her special training. She knows that men in the armed services are demanding good

PUBLIC HEALTH NURSING

obstetric care for their wives who are giving birth to their children. They want concrete assurances that this care will be given to their wives while they are fighting at the front.

Babies have become important to young parents and to grandparents. Maternal care programs in certain communities are subjected to many new pressures of work. There are fewer doctors to do the essential work and more patients to serve. The public health nurse has to work in a setup that teeters precariously on an old philosophy of private practice and a new philosophy of health and sickness care. Many a nurse, new in such a situation, wonders whether to attempt to give service to the people in her community under such circumstances, or to join the Army and forget the whole confused civilian mess.

The Army sounds to her like law and order—a place where she will get clear orders and where she may succeed in doing the right thing for the right person at the right time. But these ideas come in moments of depression. The other side of the picture is the challenging one.

Nurses are needed to do this pioneer work and they need to be our best prepared women. This is the time, if ever, to show what public health nurses can do. Maternity care is a field of service which shows quick results in community understanding and appreciation. Nurses with a knowledge of the art and science of obstetrics, and of public health, can find ways of achieving obstetric objectives in pitifully poor communities. We desperately need nurses better prepared for their jobs than the average nurse can be expected to be—nurses who will keep better records and know that their services, supplementing medical care, are safe. We need nurses who will see to it that their functions are understood by the people in the community and that the community knows that they are just one factor in a total health and sickness program. We have too few public health nurses working in the pioneer communities today. And we must have more.

HATTIE HEMSCHMEYER, R.N.

ASSISTANT DIRECTOR

MATERNITY CENTER ASSOCIATION

Coordinated Care for the Patient

NEVER MORE than in 1943 have we needed practical suggestions for coordinating the medical and nursing service rendered in the hospital with that given in the home. We have neither money to waste on expensive care that is not carried through to completion nor professional nursing care to "do over" incomplete jobs. That is why Miss Miller's suggestions in her article on "Home Care of Crippled Children" are

refreshing. Children in Iowa are fortunate to have the benefits of such a coordinated service!

One of the interesting parts of this report is the recognition that these patients are referred because they need continued nursing service—often quite apart from the social services that they may need equally as well. Doubtless there are many who need social service without any

(Continued on page 291)

Meeting Problems on the Family Health Front

By ALTA E. DINES, R.N.

FOUR problems of maternal welfare and child health as a part of family health still present an important front for conquest.

Problem 1. Inadequate preparation for parenthood.

Problem 2. Lack of the positive health concept.

Problem 3. Lack of continuity in service to individuals.

Problem 4. Lack of coordination of services for the family.

By "family health" is meant the sum total of top physical and mental fitness for every person in the family as well as healthful living together of the family as a whole. Family health can flourish only where there is a health producing home atmosphere, acceptable housekeeping, an accepted degree of orderly sharing and unselfish discipline. The health of every person in the family is affected by the regularity and adequacy of the family meals—and the way those meals are served is often as important as the actual food values. Family health is affected by the number of beds and bedrooms, by the schedule of use of the family bathroom, by closet space, by plumbing, by ventilation, by the cleanliness and protection of food and water, by the attractiveness of the house, by the family companionship and consideration each for the other. Income available definitely tempers the possibility of health for the

family. The income decreased or discontinued imperils that possibility.

An adequate standard of living, knowledge of the rules of hygiene coupled with compliance are necessary for health. Even the use of medical care, so important to the restoration of health and protection against disease, is conditioned by the value placed upon it by the family.

Maternal, child and family well-being are interdependent. Since 100 years ago when Oliver Wendell Holmes made his great contributions to maternal welfare, increased knowledge and increasing application of that knowledge have resulted in remarkably decreased death and sickness rates. Yet, positive family health—physical, mental, spiritual—is still a goal to be attained. It is threatened by the intensified social and economic pressures of today and the tendency of young people to leave home and live under anything but healthful conditions. This tendency is reflected in the widespread acceptance by young people, married or unmarried, especially in our large cities, of the idea that it is impossible or not worthwhile to establish homes. Young women as well as young men work long, hard days and are tired at night. They "go home" to a furnished room, grading up if and as wages grade up. Many eat always in restaurants, many inadequately in their rooms. Often recreation and stimulation come from late hours. Sometimes and for varying psychological and social reasons

health-giving recreation is dangerously pushed aside or into the future.

THE implications of these statements are clear in Problem 1, met often in a family health service, "Lack of a foundation on which to build healthful parenthood and home life." Where and how often do we find adequate preparation for parenthood and homemaking. Health is not a state that begins or ends at any one moment. When pregnancy is realized, in or out of marriage, the expectant father and mother of whatever economic status do not suddenly become aware of the profound values in family living—often such values are swallowed up in the dilemma. They find themselves afraid, "caught in a trap," needing outside help and direction instead of being glad and ready to meet their own problems, problems inherent in this natural new relationship and new responsibility. Can we feel content until our boys and girls have ready access to simple, direct, scientifically accurate facts about human life—health, marriage, reproduction, homemaking—presented on a level which is sound educationally and which inspires behavior that will insure a progressive social consciousness and enriched family living?

Educators, especially teachers of human biology, have much to contribute to the release of our young people from their state of sophisticated semi-ignorance. Doctors and public health nurses have a particularly heavy responsibility and a rare opportunity to help in this area of need. They can enrich the content of medical and nursing service to parents and children. Because of the relationship of trust between doctor and patient, nurse and patient, and because of the general acceptance of the idea that doctor and nurse have knowledge and experience in matters pertaining to the body, they can

effectively encourage habits of health and teach the truths which will often dislodge fear and unhappiness. The medical examination used as a health inventory is of great value if there is careful interpretation and follow-up. Sound knowledge, appreciation of personal hygiene and good health habits acquired in childhood and adolescence play an important part in preparing young men and young women for healthful maternity and paternity. Certainly, it is important for boys and girls now, in view of the immensity of problems relating to home and family health which have already resulted from the war and which will multiply as the war progresses and peace comes. Homes have been disrupted. With fathers gone, mothers in industry, children are the victims of the social upheaval. Hasty war marriages and pregnancies find young women with neither homes nor husbands. What of their children? The majority of our marriageable-age young men and many of our young women have been plunged into the intensities and temptations of war. There is a tremendously increased emphasis in sentiment about home and the family values for which our men and boys are fighting, but there is also the overwhelming urge to live for the moment, to satisfy the appetites so acutely stimulated, because life itself is so uncertain. When demobilization takes place, the import of these war experiences and moods on home life and family health will be terrific. We should be better prepared than we are to meet the needs. It surely is the collective responsibility of all of us here to give the children of today accurate knowledge of facts and understanding upon which they can build healthy family life.

IN Problem 2 we acknowledge our shortcomings in regard to the matter of a

"positive health concept," in spite of our publicized programs of service. This is a tragic fact, less true in our service to children than to others. So often when "health services" are referred to, *sickness services* are meant. Now of course the cure of disease is very often necessary if health is to be attained. However, curative service is the negative aspect of health service. Prevention of disease becomes more positive, but the really positive service aims at the implantation and nourishment of the idea of health, not just freedom from disease but that desirable state of mind and body which frees all of a person's powers in happy and easy functioning.

In completeness of service to the individual, or Problem 3, does our plan of maternal health encompass this idea of positive health? Does it even mean health for the "whole person?" Do you know that often the maternity examination does not include a chest X-ray although the highest rate for tuberculosis is among women of childbearing age and tuberculosis is most important to the pregnant woman? I recall that not long ago a mother about to be dismissed from one of our better maternity hospitals died of a pulmonary hemorrhage from an undiscovered tuberculous lesion. And believe it or not, I know patients with diagnosed tuberculosis who go regularly for years to tuberculosis experts, yet who never have a complete physical examination. Other women feel safe after a so-called health examination, including neither X-ray nor Wassermann test, nor, most remarkable of all, any gynecological examination. I could quote many instances of pregnant women whose fears, worries, and unsolved problems which made *maternal health* impossible were undiscovered in the maternity clinic regularly attended.

WHEN it comes to translating "family health" into action, too often the workers have meant curative service in home or clinic for one person plus whatever casual advisory service to others in the family could be given by the way. There have been no careful explanations, encouragement, follow-up, often no contact with other members of the family. This is our Problem 4. Family health service is rewarding in results but it is time-consuming. It must be fitted to the family needs. Many families need prolonged guidance and help to become self-directing. Even the self-directing families need health education in varying degrees and advice from those who know the available resources for health protection according to their specific needs and means. One of the Red Cross aims is to have at least one person in every home well taught and practiced in home nursing. First aid and safety in the home are also important. These are a part of family health. But with all our hospitals and health centers, all our doctors and nurses and social workers, we are still far from that harmonious continuity of service which is needed for individual and family health. There are tragic gaps and spotty medical service, not necessarily too little. One big city family I remember had contact with 11 clinics in four hospitals. The nurse interested in the family's health had a neat job of interpretation and coordination. Families report to us that the interesting cases are gladly received in the hospital a half block away from home, the more ill but uninteresting case in the same family is sent to a hospital much farther away. In two instances I have known of tuberculous patients who were also diabetic, under care of a tuberculosis clinic in a hospital in one part of town and under a diabetic clinic in another hospital in another part of

PUBLIC HEALTH NURSING

town. We need a reasonable degree of continuity of service for the individual and the family.

Looking toward the rebuilding of the world, no grouping of human beings can compare in potential significance with the family. Mothers and fathers bring children into the world to make the future—the healthier the mothers and fathers, the healthier the children, the more promising the future.

We need greater coordination of serv-

ices for the family. Often there is confusion instead of clarity even among the workers. We need to analyze our community needs, study our community resources, divide our community responsibilities, respect each other's programs and pull together if there is to be effective family health service.

From a talk delivered at the 100th anniversary celebration of Dr. Oliver Wendell Holmes' famous essay on "The Contagiousness of Puerperal Fever," New York, N. Y., February 19.

Merger of Rural and City Nursing Services

DURING the summer of 1939 a District Health Service was organized in the north central part of the State of Iowa. The office of the health personnel was established in Fort Dodge, county seat of Webster county, which has a combined population of 45,000. The city of Fort Dodge serves as a shopping center for a large rural population.

A survey of health needs, facilities, and services was made. The public health nursing services were typical of those in counties and communities of this size in the state—one county nurse supported entirely from tax funds, one city school nurse employed by the board of education, two industrial nurses, and one visiting nurse whose budget consisted in part of tax funds but mainly of community chest and other nonofficial funds.

Upon the organization of the District Health Service, the rural public health nursing service with the one nurse became part of the local health unit. A second nurse, salary from the state venereal disease budget, was added. With the exception of delivery services, these nurses carry a generalized nursing program. The

other nursing services of the city continued with their program of work as in the past. In the main, the one visiting nurse assisted physicians with home deliveries and gave daily postpartum care to patients.

From time to time we had offered consultation to this city service, suggesting that a well-qualified nurse assistant be employed or that such a nurse from our staff be assigned for part-time assistance. After 26 years of service, and due to ill health, the visiting nurse resigned in June 1942. The board informed the Community Chest that they were no longer functioning as a service.

At once the county board of supervisors and the welfare office requested the county public health nursing service to give care to needy and urgent cases. Several other agencies, including the anti-tuberculosis association and the Red Cross planned to have their health services integrated into a standard nursing service. This presented an opportunity to reorganize the city service.

With professional guidance, a few key people set up a committee with this ob-

MERGER OF NURSING SERVICES

jective. Members of the recently disbanded visiting nurse board were asked to participate in the reorganization. It gave us pleasure to learn that about half of the members wished to be part of the new organization.

We were able to combine the office of the community nurse with that of the county nurses who have spacious, well-equipped quarters, with full-time clerical help. We secured a qualified nurse who was happy to accept the guidance of the district advisory nurse and the other public health nurses in the combined service. A uniform record system is now used by both services.

The community nurse continues to assist the doctors with home delivery service in addition to morbidity and health supervision service. A part-time nurse was added to the staff October 1, and the present budget will take care of a second full-time nurse.

Since January 1, the new community nurse has had an executive board with representatives from cooperating organizations. Policies have been adopted, officers elected, and standing orders have been approved by the physicians. The new service is meeting with general public approval.

It gave us pleasure to be able to give some guidance to the organization of this service and to be invited to continue in an advisory capacity. Already several agencies recognize the fact that the integration of the rural and city services has been economical and convenient. Only one office need be called for all types of public health nursing services to families in homes.

The school and industrial nurses give specialized services in their respective fields. However, active rapport and an effective exchange of services between all the public health nurses has developed to an appreciable extent. Planned education meetings with state consultants and the district advisory nursing services should guide the nurses and lay members in their appreciation of public health nursing.

Due to the fact that nursing is undergoing such rapid changes at the present time, it is hoped that in the very near future we may have an executive committee with representation from both rural and city lay boards to assist us with new policies to meet ever-changing needs.

ELIZABETH WYSS, R.N.

ADVISORY NURSE
DISTRICT HEALTH SERVICE No. 5, IOWA

ADDITIONAL SUMMER COURSES

California.

Berkeley. University of California. July 1-October 23, Health Teaching, The Nurse in Public Health, The Field of Public Health Nursing, Field Instruction in Public Health Nursing. Other courses of interest to public health nurses in economics, education, physiology and psychology. For further information write to Margaret Tracy, director, School of Nursing.

Pennsylvania.

Philadelphia. University of Pennsylvania. June 21-July 10, Special phases of public health nursing—tuberculosis, industrial health, and services to the sick. July 12-July 31, Organization and administration in public health nursing.

For further information write to Katharine Tucker, director, Department of Nursing Education, School of Education, Bennett Hall, 34th and Walnut Streets.

Preserving Confidence in Health Instruction

BY MAYHEW DERRYBERRY AND GEORGIE S. BROCKETT

IN AN INFANT hygiene visit the mother looks to the nurse for an explanation of the most nearly scientifically correct procedures for caring for her child. Moreover, the nurse is often called upon to dispel the confusion left in the mind of the mother by the conflicting remarks of well-intentioned relatives and friends. To meet such situations successfully, the nurse must give the most accurate information known to her profession in a way that the mother can grasp.

Nor is it enough that she give advice in general terms. She must be conscious of her position as a health educator. Many times, her directions are the mother's creed. Unless the nurse explains her reasons when giving advice, the mother who receives special instruction may pass it on to her neighbor as general advice equally applicable to any infant. Quite possibly she will compare the advice she obtains from one nurse with that received by a friend from a different nurse. Do nurses when giving instructions concerning infant care keep these possibilities in mind?

Included in the data from the nursing survey conducted by this division* are about 400 transcripts of infant home nursing visits. All the instruction that the nurse offered during the course of these home calls has been indexed and cross-

indexed according to the subject or subjects under discussion. In this way, advice on a certain item given by one nurse can be compared with that given by other nurses participating in the study.

In analyzing these data it became apparent that although nurses give consistent advice on most of the problems that figure in a home nursing call, there are certain items upon which they give varying or contradictory instruction. If nurses do not agree as to the correct instruction, it tends to add to, rather than overcome, the mothers' bewilderment. One nurse may instruct Mrs. A. that a certain procedure is correct, while another nurse tells Mrs. B. not to use that method since, as is frequently said, "We do not advise that any more." If Mrs. A. and Mrs. B. compare notes they are then apt to discount further advice from that health agency.

Since it takes so little to discredit a public service, attention is called to certain conflicting statements in the hope that nurses may be able to attain greater standardization in their teaching.

It is felt that presenting excerpts from transcripts of nurses' home visits containing their verbatim instructions upon certain items may illustrate these problems more effectively than any words of the authors. The items selected for presentation were not chosen with the thought that they were of vital importance in themselves. They were used only because they offered the most concise illustrations

*Derryberry, Mayhew. "The Nurse as a Family Teacher." *PUBLIC HEALTH NURSING*, June 1938, p. 357.

HEALTH INSTRUCTION

of the problems involved. These abstracts were checked carefully with the original transcripts and with the case and clinic records for evidence of individual differences between one infant and another that might account for the inconsistencies found between the advice given by one nurse and that offered by another. None was found.

One situation that calls forth much conflicting instruction is breast feeding. In many instances the various nurses give either contradictory or divergent instruction both upon the method and the length of time to be devoted to the process.

In the first place, nurses do not agree as to whether the baby should nurse one or both breasts during each feeding period. Below are abstracts of several cases drawn from the verbatim transcripts of the nurses' visits. They reveal contradictory instruction in the actual words of the nurse:

Case 1

NURSE: *Nurse on the right breast for one feeding and the next feeding on the left breast. You can change the ring on your finger, so you can remember which one you nursed her on last. When you nurse your baby on the right breast, change the ring to the left finger. Then you will know that the next time you are to nurse it on the left breast.*

In the section of the transcript devoted to postpartum care the mother informs the nurse that her breasts are "all right." There is no suggestion that the supply of milk is involved. It appears to be a problem of keeping the baby on schedule.

Another nurse offers this instruction to her client:

Case 2

NURSE: *You feed her on both breasts?*

MRS.: *Just on one.*

NURSE: *Why don't you try nursing her on each side? Ten minutes on each side and in that way your breasts—it stimulates both sides at the same time.*

* * * * *

NURSE: *That's what we teach the mothers—*

to give the babies the breasts on both sides. In that way the baby gets the benefit of all the milk the mother has.

In the abstracts cited above one nurse advocated feeding the baby on only one breast during a feeding period. The other nurse converses with a mother who nurses her baby on only one breast at a feeding and instructs the mother to employ both breasts each time. Whether it is correct to use one or both breasts at a feeding involves a medical principle upon which the authors do not presume to pass judgment. As we have stated before, our only intention is to point out the inconsistencies and the contradictions as they appear in the material.

The next problem involves the length of time a baby may nurse at one feeding. The nurses' suggestions as to the amount of time to be allowed for each feeding varies from 10 to 20 minutes. In the first two of the cases offered below the nurses give no reason for insisting that the babies nurse for a particular length of time.

Case 1

NURSE: *I wouldn't nurse the baby much more than 10 minutes now, hear? And every four hours, hear?*

MRS.: *Yes, Ma'am.*

Case 2

NURSE: *Do you feed him regularly?*

MRS.: *Yes. I give him seven bottles. Every three hours I feed him, but sometimes he doesn't finish it all.*

NURSE: *If he nurses for 15 full minutes and then he falls asleep or doesn't want it any more, don't force him. Nurse him for 15 full minutes.*

* * * * *

NURSE: *If the baby hasn't completely finished the bottle in 20 minutes at the most, don't force him to finish it. If you were nursing him at the breast, you would take the baby from the breast after he had nursed 15 minutes. And it is the same with the bottle.*

MRS.: *All right.*

In the next case the nurse states that babies should be at the breast for 20

PUBLIC HEALTH NURSING

minutes at each feeding time. This nurse reasons as follows:

Case 3

MRS.: She don't get enough. She only nurses about three minutes.

NURSE: I think she will want you to keep her awake and nurse her for more than three minutes. She needs the exercise for her tongue and throat muscles, and if you are not feeding her so often, she will be hungrier and she will have a better appetite, and will nurse longer when she has the opportunity. *Doctors that have studied babies very carefully tell us they should be at the breast 20 minutes at each feeding time.*

NURSE: You always change the diaper before you put her to nurse?

MRS.: Yes.

NURSE: If you change the diaper and wash her buttocks, that will help to awaken her.

MRS.: I always do.

NURSE: Then rub her back and her legs and rub her forehead. That helps to awaken her. So get her thoroughly awakened before you start to feed her and do everything possible to keep her awake for 20 minutes. *If they don't nurse for fully 20 minutes, they are apt to take to thumb sucking, because they need the exercise of nursing for 20 minutes, and then after that they are satisfied and they don't want to put their thumbs in their mouths.*

What is to prevent the first mother from believing that all babies should nurse 10 minutes? The second mother must think that babies should be nursed for 15 minutes and the third mother has reason to believe that 20 minutes is the correct time for nursing. The advice seemingly is general. When each of these mothers is afforded opportunity she will pass on this instruction as information applicable to her neighbor's baby as well as to her own. Much of this confusion might be dispelled if nurses could explain that in consideration of the activity or some other characteristic of the infant the interval advised would prove most satisfactory for that infant at that time.

Another point of controversy is the use of powder versus oil. Two nurses from

the same health department explain to their clients as follows:

Case 1

NURSE: Now, you make your own powder puff, just a little piece of cotton like this. You don't take the can and pour it on for we don't do it that way. It would be a good idea to get a jar as you have for your own.

MRS.: Not any oil?

NURSE: *No, we don't oil the baby any more because oil is a field for infection.* If the baby had a pimple, it would only increase the size of the pimple, and we don't use oil any more at all. Keep the skin dry and use powder sparingly.

Case 2

NURSE: I noticed you have been putting powder on him, haven't you?

MRS.: Yes.

NURSE: Did they tell you to in the hospital?

MRS.: Either that or the olive oil. I put powder on him when I change him.

* * * * *

NURSE: *Now, we don't put any powder on.*

The two cases above show one nurse in the department advising the use of powder and giving a definite but general reason for not using oil, while the second nurse goes as far as she is permitted in discouraging the use of powder, when she finds that the hospital has endorsed both. This problem is not confined to one locality. The following abstract is from a different city:

Case 3

NURSE: *Oil helps the baby to grow, too. Olive oil makes the skin good and firm. All babies like to be greased but they don't enjoy powder, and that's why we don't use powder any more. You know way back they used powder. I see you have a can of powder on the tray, but I would ask you to use olive oil always here.*

A nurse in still another city recommends that the mother discard both powder and oil. Her instruction is quoted in Case 4.

Case 4

NURSE: I don't think you will need that oil. The doctors feel now, that oil is not particularly desirable for babies' skin, because

HEALTH INSTRUCTION

they have recently decided that it causes the skin to slough off in the creases, so now *the trend is toward soap and water baths—no powder and no oil*, unless the doctor at the clinic feels the skin is too dry. She has probably been given oil baths, and see how raw it is in here? The only thing you can do is to keep it clean and dry.

Phrases such as, "We don't use powder any more," "We don't oil the baby any more," "The trend is toward soap and water" not only express three conflicting opinions in the words of the nurses, but they indicate that the nurses are not addressing problem cases. Each nurse appears to be giving the advice that she regularly offers when the question of powder or oil arises. Cannot some agreement be reached as to the most successful method? If one method might be decided upon for ordinary use, then where an infant requires special treatment the reason for the divergent advice might be called to the attention of the mother. This reveals the need for less didactic instruction and more instruction along the line of: "This is what pediatricians believe is best at the present time."

Differences among nurses were also revealed with respect to the frequency of shampooing a baby's head. The following cases illustrate the contrasting advice of nurses, with their accompanying reasons:

Case 1

NURSE: *We shampoo the head now every other day instead of every day.*

MRS.: I do that. Because a baby's head doesn't need to be washed every day.

NURSE: No, I really don't think you need to do it every day.

Case 2

NURSE: *You wash the head every day?*

MRS.: Oh, yes.

NURSE: *Some mothers don't and then it's easy to get that cradle cap.*

MRS.: Yes, I wash it every day.

It should not be difficult to reach a decision as to the advisability of washing the

baby's head daily. It either is or is not a good method.

Another question that provokes conflicting suggestions is: "Should cod liver oil be given during the summer months?" Here again nurses in the same agency do not give consistent advice. In the first of the two cases that follow, the nurse agrees with the mother that it is too hot to give the oil in the summer time. In the second case, a nurse believes and advises that a more concentrated form of the oil might be given during the hot weather.

Case 1

NURSE: Does she take cod liver oil?

MRS.: It upsets her.

NURSE: Well, it is too hot for her now. She can get the sun now. *From October to May is the time to give her cod liver oil.*

Case 2

NURSE: I think she really ought to have some cod liver oil in the concentrated form.

MRS.: I gave it to her before, but now it's too hot.

NURSE: The doctor at the clinic might like you to give her a concentrated form and we have a few samples and maybe we could give you some. . . . *I think she probably needs some cod liver oil this summer* for they can give you a different type than you have and we have some samples there. The nurse, I feel sure, can give you some.

Besides the problem about the seasons of the year in which to give cod liver oil, there is another question as to its use. It is: "Should cod liver oil be mixed with orange juice before giving it to the baby?" Two nurses from the same agency answered that question with the conflicting advice that follows:

Case 1

NURSE: Do you give her cod liver oil?

MRS.: Two times a day. She cries for more, but she cannot have it.

NURSE: How do you give it, just plain?

MRS.: With orange juice is all.

NURSE: *That is the way you should.*

Case 2

MRS.: I will. I have been giving him the cod liver oil. The doctor told me to give it to

PUBLIC HEALTH NURSING

him. I give the cod liver oil first and then the orange juice.

NURSE: Yes, *don't mix it*. The baby has not much understanding of taste yet, but later it might turn against the orange juice if you mix it with cod liver oil now. *First give the baby the cod liver oil and then use a clean glass for the orange juice*. Then he won't connect the two tastes.

MRS.: I use the same spoon.

NURSE: See the cod liver oil is on that spoon, so don't use the same spoon for the orange juice.

MRS.: Shall I wait a few minutes?

NURSE: No. Right away, right after you give him the cod liver oil give him the orange juice, but make it like two courses. Cod liver oil is the first course and the orange juice is the second course. If you want to give him the orange juice out of the bottle that is all right too.

The nurses advise each mother that her way of giving cod liver oil is the correct one. Seemingly, both mothers are successful. Yet, in neither case does the nurse indicate that the other method might work. What will these two mothers believe if they compare experiences?

However, the question that calls forth the greatest amount of divergent information is that of the amount of water that a baby requires each day under apparently similar circumstances.

For example, in the following cases, the mothers of two infants, each less than two weeks old, are informed about the necessity of water for infants.

Case 1

MRS.: Should he have water every day, now?

NURSE: Yes. Offer him water every day between his feedings; *but don't be too concerned if he doesn't take very much*.

Case 2

NURSE: How does it like the water—like the water all right?

MRS.: He won't drink it.

NURSE: *Well, you must try to force him then, because he soon won't take any at all if you don't start early*.

In the first case one nurse counsels a mother not to "be concerned" if her baby

does not take very much water, while in the second case the nurse insists that if a baby does not take water, "You must try to force him, then." Either these nurses offer divergent opinions because of differences in training and experience, or such advice is dictated by the policies of their respective agencies.

In the next situation the babies are each four months old. Each is visited during the summer by nurses from the same agency. The first nurse inquires:

Case 3

NURSE: How much water between nursings?

MRS.: One ounce.

NURSE: And you feed her every four hours?

MRS.: Yes.

NURSE: You must get *about four ounces* of water in her, during the day.

Case 4

NURSE: How much water do you give her?

MRS.: *Four ounces a day* in the morning before her bottle.

NURSE: *That isn't enough*. She ought to take more.

Note that in the first instance the nurse advises a mother to allow her baby about four ounces a day, but, in the next illustration, a different nurse informs the mother of an infant of like age (who is at present receiving four ounces of water) that that is not enough!

A third situation involves two infants, each less than one month old. The mothers of both children receive their instruction during the winter months. Yet, as the following excerpts show, the nurses' instructions about the amount of water that each requires vary from two to eight ounces a day:

Case 5

NURSE: How much water does he take?

MRS.: *About two ounces a day*. That is all.

NURSE: *That is plenty*, just so he gets some, because they should have water besides their feedings.

Case 6

NURSE: How much water do you give him?

MRS.: One ounce in a day. For a day's time. Is that enough?

HEALTH INSTRUCTION

NURSE: No. They should take at least an ounce or two ounces between each feeding. . . . *They should average six to eight ounces in 24 hours.*

Differences in the individual child, in medical orders, or in nursing practices must be responsible for the variety of instruction apparent in these and former illustrations. However, in making comparisons, great care was taken to use only cases for which case records reveal no individual differences that would account for such a variety of instruction.

Secondly, it is not overlooked that much of the apparent inconsistency in nursing instruction may be attributed to medical orders. Unfortunately, the extent to which this applies in the cases cited cannot be determined. In only two of the 21 cases presented were physicians' orders, even remotely related to the subject, found in the files of the health department. Of course, with the exception of breast feeding, the items discussed here are not those on which specific orders might be routinely expected from a physician before each nursing visit.

In regard to the third possibility—that of lack of uniformity in nursing practice—the data were analyzed in relation to the individual nurse, nurses from the same department, and nurses from different cities.

Although the number of transcripts for each nurse is limited, when comparison is made of the instruction a nurse gives in one home with that which she offers in another, it is evident that the advice of the individual nurse is consistent. This is another indication that nurse differences rather than differences among infants account for divergence in the instruction.

Further indication of nurse differences was pointed out in presenting the abstracts. A lack of consistency was apparent in the teaching by nurses in the

same organization as well as in that of nurses in different cities. However, in the greater proportion of the cases the conflict in instruction was found in the transcripts of visits by nurses from different agencies.

SUMMARY

There are, of course, other problems upon which nurses disagree that are not touched upon in these transcripts. However, those found most frequently in the survey material have been given. They may be summarized as follows:

1. Breast feeding.
 - a. Length of time allowed for each feeding.
 - b. Employment of one or both breasts at each feeding.
2. Use of powder versus the use of oil.
3. Frequency of washing the baby's head.
4. Cod liver oil.
 - a. Season of the year to administer.
 - b. To give alone or to mix with orange juice.
5. Amount of water required by an infant.

There is evidence that, in most instances, such differences may be attributed either to differences in the opinions held by individual nurses or to variation in policy among the several nursing departments. Is there not need for more consistent methods of doing many of the things that are now dismissed as "matters of opinion?"

It has long been recognized that both physicians and nurses tend to repeat in the field the techniques in vogue in the hospital in which they trained. Is it not desirable that physicians, administrators, and instructors of public health nursing formulate a more unified opinion concerning such controversial issues? The accuracy of the information supplied is an

essential component of all education. Is this axiom any less important when applied to public health education?

Not only is failure on the part of the nurse to impart the best available information to a given patient involved, but the confidence of the public runs the risk of being compromised. Confidence is a fickle thing. To damage it in one activity

is to cast a reflection on any other activity of the agency responsible.

Are or are not these matters important? If important, is not the health education program in the child hygiene field being jeopardized by conflicting advice? Here is an opportunity at least for the various nursing organizations and schools of nursing to coordinate their instruction.

Comment on "Preserving Confidence in Health Instruction"

THE ARTICLE by Dr. Derryberry and Miss Brockett will be interesting to public health nurses as it will raise definite questions in their minds. The importance of giving scientifically correct information to parents would be granted as a major responsibility of the nurse. Nevertheless, this is somewhat difficult with regard to certain points. Reference to the existing literature in the field of pediatrics reveals differing points of view on many of the subjects which are discussed in the preceding article. Until that day arrives when there is complete and universal acceptance of points of view, it would seem inevitable that in material such as has been assembled by Dr. Derryberry and his staff, we will find the varying types of instruction given.

One wonders if greater standardization in teaching is really desirable. Is there not a far greater need for the nurse to have better scientific information and to keep abreast of changes through reading and study, than for standardization? Would that not be a more desirable objective in view of the fact that standardization to a certain extent is a negation of the principle of individual differ-

ences which we believe the nurse must keep clearly in mind if she is to be effective in helping parents? Is not the lack of specific medical instructions a point which needs more attention?

Those portions of the visits which are quoted raise a question as to the method of teaching which is being employed. Admittedly, the explanation to parents, "We now teach this" or "We don't use that any more," will not be particularly valuable to them in better understanding the reasons for a certain type of care for their child. It would appear that if sound reasons could be presented for the instruction given, there would be a greater possibility of preserving confidence in health instruction. This explanation of reasons presumes a knowledge which is based on scientific facts.

The real question with which nurses are faced is how that knowledge can be kept accurate and in line with what is currently believed to be sound. It is undeniably the responsibility of every agency through staff education and supervision to present to the staff nurses certain principles in regard to child development and training which that agency

M.O.P.H.N. ON THE JOB!

has adopted with the guidance of its medical advisory committee. A decision on controversial issues can be reached, but it will have to be borne in mind that the decision is not necessarily a permanent one, but is subject to change in itself, and subject to modification according to the needs of the child. It is also important that time be spent by the staff of an agency in discussion of what constitutes the general body of knowledge which they

will attempt to teach. Time thus spent should be productive in stimulating the staff to be more critical of the type of instruction they are giving, and of their own methods of teaching. Self-analysis of this sort should result in service to parents which will enable them to place more confidence in health instruction.

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M.O.P.H.N. ON THE JOB!

WITH THE loss of 32 public health nurses from the home front to the military services, the Lay Section of the Minnesota Organization for Public Health Nursing in March decided to take action. A letter to all nursing committees and boards in the state pointed out its recognition of the needs of the armed forces, but at the same time emphasized the urgency for protecting civilian health and maintaining existing public health nursing services. Statements by State Health Officer A. J. Chesley, M.D., and Dr. S. H. Baxter, president of the Minnesota Medical Association, verifying the truth of M.O.P.H.N.'s claims, were enclosed. Said Dr. Chesley: "Many public health nurses have left critical civilian positions to go into military service. These public health nurses have been specifically trained for the administration of civilian health programs of a highly specialized nature. They cannot be replaced by nurses without this special training regardless of their ability. . . . Home care of the sick has grown in importance in Minnesota because more than one third of Minnesota's physicians are already in the Armed Forces, the rural areas having reached the minimum number of physicians essential to safety.

Hospitals are overcrowded. It is therefore necessary to maintain public health nursing services under the direction of remaining physicians to aid them in the care of the sick. . . . We need more public health nurses in Minnesota. During peacetime we could have used many more public health nurses, since 45 of our counties lacked even one nurse. During war, with more responsibilities necessarily placed upon the public health nurses, we cannot afford to lose even one more nurse who is trained in public health." And Dr. Baxter: "I am glad to have this chance to urge such nurses on behalf of the medical profession of the state to remain at their posts during the emergency to assist physicians here at home. . . . The trained public health nurse, with her practical experience in so many aspects of communicable disease control and of school health, is a vital factor in our organization for preventing wartime epidemics, for extending essential public knowledge about nutrition and hygiene and for maintaining all our community health services."

This action was the first big gun fired in the publicity campaign to inform the public of the need for public health nursing services on the home front.

SCHOOLS APPROVED FOR TRAINING PHYSICAL THERAPY TECHNICIANS **By the Council on Medical Education and Hospitals of the American Medical Association**

Name and Location of School	Entrance Requirements*	Emergency Course			Regular Course				
		Length in Months	Classes Start	Tuition	Certificate, Degree, Diploma	Length in Months	Classes Start	Tuition	Certificate, Degree, Diploma
Children's Hospital, Los Angeles 1	a-b-c	6	Feb. Aug.	\$200	Certificate	12	Feb. Aug.	\$200	Diploma
College of Medical Evangelists, Los Angeles 1	a-b-c	--	--	--	--	12	Jan. July	\$200	Certificate
University of California Hospital, San Francisco 1	a-b-c	--	--	--	--	12	Feb.	\$150	Certificate
Stanford University, Stanford University, Calif. 1	a-b-d ²	7	Quart.	\$286	Certificate	10	Quart.	\$401	Cert. or Degree
Walter Reed General Hospital, Washington, D. C.	b	6	Quart.	None	Certificate	--	--	--	--
Northwestern University Medical School, Chicago	a-b-d	--	--	--	--	9	July Oct.	\$200	Certificate
State University of Iowa Medical School, Iowa City	b-c	6	Mar. Sept.	None	Certificate	--	--	--	--
Bouve-Boston School of Physical Education, Boston	HS	Given	in conjunction with	\$200	Harvard Certificate	3-4 yrs.	Sept. June	\$400 yr.	Dipl. or Degree
Harvard Medical School, Boston	a-b-c	6	June	--	Certificate	9	--	\$250	Certificate
Boston University Sargent College of Physical Education, Cambridge, Mass.	--	--	--	--	--	24	Jan. Oct.	\$435 yr.	Cert. & Degree
University of Minnesota, Minneapolis 1	a-b-c ³	--	--	--	--	12	Summer	\$1124	Certificate
Mayo Clinic, Rochester, Minn. 1	a-b-c	6	Jan. July	None	Certificate	12	Jan. July	None	Certificate
Barnes Hospital, St. Louis	a-b-c	--	--	--	--	9	Oct.	\$200	Certificate
St. Louis University School of Nursing, St. Louis 1	HS	--	--	--	--	4 yrs.	Jan. Sept.	\$250 yr.	Cert. or Degree
University of Buffalo School of Nursing, Buffalo 1	a-b-c	6	Feb. Sept.	\$420	Certificate	1-3 yrs.	Feb. Sept.	\$350	Cert. or Degree
Hospital for Special Surgery, New York City 1	a-b-c	6	Jan. July	\$500	Diploma	9	Sept.	\$300	Diploma
New York University, New York City 1	a-b-c	--	--	--	--	9	Feb. Sept.	\$396	Cert. & Degree
Cleveland Clinic Foundation Hospital, Cleveland	a-b-c	--	--	--	--	9	Sept.	None	Certificate
D. T. Watson School of Physiotherapy, Lectdale, Pa. 1	a-b-c	6	Jan. July	\$200	Diploma	12	July	\$200	Diploma
Graduate Hosp. of the Univ. of Pennsylvania, Philadelphia 1	a-b-c	--	--	--	--	12	Sept.	\$200	Certificate
Richmond Professional Institute, Richmond, Va.	a-d ⁵	--	--	--	--	9-12	Sept.	\$200-220	Certificate
University of Wisconsin Medical School, Madison 1	a-b	6	Feb. Sept.	\$964	Certificate	12	Sept.	\$964	Certificate

* Courses are so arranged that any of the entrance requirements will qualify students for training: a = Graduation from accredited school of nursing; b = Graduation from accredited school of physical education; c = Two years of college with science courses; d = Three years of college with science courses; HS = High school graduation; 1. Male students are admitted.

2. High school graduates accepted for a four-year course leading to A.B. degree; students admitted quarterly and tuition is \$143 per quarter.
 3. Medical technology graduates with B.S. degree also admitted.
 4. Nonresidents charged additional fee.
 5. Those with degree from other colleges also accepted.



Health officer and public health nurse are on a regular tour to dispense drugs to treat malaria and discover new cases

The Public Health Nurse in Malaria Control

By E. L. BISHOP, M.D.

THE PUBLIC health nurse, working closely and intimately as she does with the people of a community, oftentimes holds the key to the success or failure of a public health program. Since the War, with its attendant shortage of doctors, her importance in providing essential public health services has assumed and continues to assume increasing magnitude. The exigencies of war frequently give rise to many new health problems or accentuate those that have previously been of only limited extent. Every pub-

lic health worker must be on the lookout for ways and means of combating these developments. The problem of malaria, though in more recent years confined largely to certain sections of the United States, could very well assume national significance because of certain factors associated with the War. The public health nurse can play a significant role along with health officers and engineers, research workers and technicians, in the fight to forestall this development. To do so, it is highly essential that she have

PUBLIC HEALTH NURSING

certain basic information about the diagnosis, treatment, and epidemiology of malaria.

HISTORY

It has become almost axiomatic that social and economic changes brought about by war are conducive to an increase in malaria transmission rates. Chapin¹ records the recurrence of malaria in New England following the return of Union troops to their homes from endemic situations in the South. The inferences he draws are, of course, conditioned by the fact that the mechanism of malaria transmission was unknown at the time and that apparently the recent discovery of the malaria parasite was unfamiliar to him. Hackett² records that following World War I there was a widespread increase in malaria throughout southern Europe, amounting to epidemics in certain situations, notably in the Don Valley in 1922-1923.

These wartime and postwar increases in malaria transmission rates are due to a number of factors, of which some of the most important are: (1) relaxation of control measures directed toward mosquito larvae and adults (2) inadequate treatment of cases, due to shortage of drugs and professional care (3) lowered resistance of populations, due to faulty nutrition and (4) shifting of populations, and consequent upsetting of immunological balances and introduction of new strains of malaria.

At the time of the Civil War malaria was disappearing rapidly north of the Ohio River and slowly in the southeastern states. This trend continued in the northeastern and north central states until, more than a generation ago, endemic malaria through that section faded out. In the South, however, the ravages of the war reversed the trend, and it was not

until about 1920 that malaria rates there began to decline significantly. This later trend has continued to date, as evidenced by lower morbidity and mortality rates and by the fact that admissions to hospitals of cases of blackwater fever and cases of *falciparum* malaria in coma now constitute a rarity, whereas formerly treatment of several such cases each summer was the normal expectation.

Insofar as this country is concerned, there has been no general relaxation of the measures, instituted in peacetime, toward malaria control through biological means. In fact the areas about military establishments and war industries have seen an accentuation of measures designed to prevent transmission of malaria. The fact remains, however, that in many parts of the eastern United States there is considerable anophelism entirely free of malaria or free of significant malaria that could be converted into endemic or epidemic centers under proper epidemiological circumstances. The basic postulates for the transmission of malaria comprise a population composed of mosquitoes and man, a population that may be divided into three primary classifications:

1. Adult female anopheline mosquitoes, with an instinct dictating the repeated taking of blood meals and with a physiology permitting the development of the extrinsic cycle of the malaria parasite.
2. Persons whose blood is accessible to the bites of *Anopheles* and contains viable gametocytes of *Plasmodium* (gametocyte carriers).
3. Individuals whose blood is equally accessible to the bites of *Anopheles* and whose physiology permits the development of the asexual cycle of the *Plasmodium* (nonimmunes).

Recently there have been many reports of the breeding of *Anopheles* mosquitoes throughout the north central and eastern states, even in South Canada, so that, throughout most of the eastern United States at least, we may accept as

MALARIA CONTROL

established the fulfillment of two of the three postulates.

PRESENT PROBLEM IN WAR AREAS

The greater portion of our troops outside continental United States are stationed south of the 45° parallel of North Latitude, and, of that portion, by far the greater number are somewhat closer to the equator. Therefore, most of our troops on foreign soil are associated rather intimately with situations where hyperendemic malaria occurs. Inevitably many of them will become infected with malaria parasites, since we have no drug that acts as a true causal prophylactic, and since the very nature of the activity of soldiers is such that prevention of biting by mosquitoes cannot be accomplished perfectly.

POSTWAR PROBLEM

Probably all soldiers returning from war areas where malaria is endemic should be looked upon as infected with malaria parasites. Since many members of our armed forces have been returned to the United States for convalescence in hospitals or have actually been discharged to their homes, the problem of malaria transmission is not confined to the period after the war, but exists now.

The problem is primarily one of need for prompt treatment and unrelenting follow-up of cases proved to have malaria, so that relapses can be treated promptly as they occur. It is believed that *Plasmodium vivax* infections tend to relapse for at least three years; *P. malariae* for five or more years and, according to evidence, sometimes for 25 years. *P. falciparum* has a somewhat shorter life, probably most of the strains dying out in the body after about a year. The last-named is likely to be the most common type found in soldiers returning from the tropics and subtropics. Infections with this parasite are the most malignant, for

death often occurs in untreated cases. It is important to remember that no drug at our disposal today will sterilize the human host of malaria parasites; that all our drugs serve merely to bring the level of parasitemia down to values that can be taken care of by the defense mechanism of the body.

From the epidemiological standpoint, the introduction of exotic strains of malaria parasites is not likely to intensify malaria problems in situations where malaria is endemic. Boyd and his co-workers^{3,4} have shown that North American anophelines are not very effective vectors of tropical strains of malaria. However, this does not mean that exotic strains of malaria cannot be transmitted by American anophelines, and it may be that certain exotic strains can be transmitted very efficiently. Therefore, the introduction of gametocyte carriers (in the person of soldiers returning from hyperendemic situations) into nonendemic areas where *Anopheles* breeding is occurring sets the stage for the transmission of malaria and may result in the establishment of epidemic or endemic foci.

INCREASED DUTIES OF PUBLIC HEALTH NURSE

These considerations emphasize the importance of finding malaria cases in returning soldiers and also in war workers who may have moved from endemic areas in the South to nonendemic areas in the North. Accurate diagnosis is necessary not only in order to secure prompt treatment of malaria but to conserve supplies of antimalaria drugs, and, because of the shortage of physicians, the burden of diagnosis of these cases is likely to fall more and more on the public health nurse. Therefore, the public health nurse should become as "malaria conscious" as she has been "tuberculosis conscious" or "venereal disease conscious" in the past.



The public health nurse can learn to prepare the glass slides with thick and thin blood films which are to be examined for malaria parasites. Making such a slide is simple and a practically painless procedure for the patient

FACTS ABOUT MALARIA

Malaria is a group of diseases caused by infection with members of the genus *Plasmodium*, of which the principal species infecting man are *vivax*, *falciparum*, and *malariae*. Soldiers returning from the west coast of Africa may have *P. ovale* infections, which—in regard to both clinical symptoms and morphology of the parasite—are quite similar to *vivax* infections. Epidemiologically, malaria may exist in three forms in a community, as (1) sporadic cases (2) endemic malaria, where the basic postulates for transmission are present to such an extent that the disease tends to persist with more or less intensity and (3) epidemic malaria where there is tendency for infection of an entire population group at about the same time, this group infection being followed by either disappearance of the disease or the establishment of an endemic focus.

The symptoms and signs of malaria are caused by the development of the parasites in red blood cells. The asexual forms complete their development in

varying lengths of time, depending on the species, at the end of which time they burst out of the red cell and enter uninfected cells. *P. vivax* completes its asexual development in about 48 hours. Therefore, the fever that occurs from the development of one crop of parasites recurs at 48-hour intervals, giving rise to tertian fever. However, we now know that in more than 80 percent of cases two sets of parasites are nearly always present, maturing on alternate days, so that fever occurs daily. *Plasmodium malariae* completes its development in about 72 hours, giving rise to quartan fever. Frequently more than one set of parasites is found, so that fever may occur daily, or, more commonly, on two out of every three days. The fever from *falciparum* infections is likely to be remittent rather than intermittent, particularly at the onset. This fever may occur daily or be tertian in character.

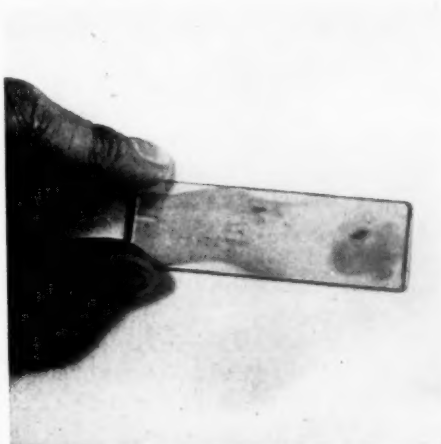
Malaria is spread by females of the mosquito genus *Anopheles*. The gametocytes or sex forms of the *Plasmodium* are taken into the mosquito's stomach, and about 15 days later the parasites have undergone a series of changes resulting in the infection of salivary glands of the mosquito with sporozoites. These forms, when introduced into human beings, reproduce the infection.

Both the propagation of mosquitoes and the development of the malaria parasites in the mosquitoes (extrinsic cycle) are dependent on atmospheric temperature. It is only during the months when the mean daily temperature exceeds 68° F. that malaria transmission can occur, so for the most part the season of active mosquito propagation and malaria transmission is confined to the summer months. There are eight species of the genus *Anopheles* in the continental United States, but of these only *quadrimaculatus* and *maculipennis* are of much epidemi-

ological significance. While all the other *Anopheles* mosquitoes can be infected and will transmit malaria under laboratory conditions, their distribution or habits tend to prevent their taking an important role in malaria transmission. In general, *Anopheles maculipennis* is confined to the West Coast and the northwestern part of the country, while *Anopheles quadrimaculatus* occurs in the east central, eastern coast, and southeastern United States, including Texas. The morphology and natural history of these two species are almost identical. Both breed in pools of clean, still water free from gross pollution with sewage or industrial waste, and their breeding places—especially the margins of the pool—are usually characterized by emergent vegetation. Both species have a preference for human blood and readily enter habitations in search of it. They can often be found in houses in relatively dark and cool situations, and tend to remain for a short time near the place where the last blood meal was taken.

DIAGNOSIS

The public health nurse should be as skillful in detecting symptoms of malaria as in detecting those of tuberculosis, venereal disease, cancer, and malnutrition. There are no pathogenic symptoms of malaria. However, fever, anemia, and enlargement of the spleen are three findings that occur almost universally with malaria infections. Most of the cases nurses will see will be relapses, and a relapse accompanied by a fever of 100° will be accompanied practically always by the presence of parasites in the blood in sufficient numbers to be detected easily in blood films. Any febrile illness in a returning soldier should be considered as possibly due to malaria, until such a possibility is confirmed or disproved by examination of blood films, and in this re-



The slide, ready for microscopic examination. Note thin blood film on left end of slide, thick film on right. Each slide should contain both since it is possible to find malaria parasites in the thick blood film, but not in the thin

gard it may be necessary to take several thick blood films before malaria can be ruled out.

Every nurse should receive special instruction in the proper preparation of blood films, for the identification of parasites in blood films is the only way to make a positive diagnosis of malaria. The technique is simple and can be mastered readily. Since it is possible to find parasites in thick blood films when they are absent from the ordinary smear, thick films should be made routinely.

The symptom most likely to be found in malaria infections is fever. Chills or chilly sensations preceding the onset of fever often occur, but may be lacking. Persons with chronic malaria are likely to be quite anemic, and white persons present a pale yellowish skin as a consequence of the anemia. With a little practice, the enlarged spleen can be felt in most cases of chronic malaria.

TREATMENT

The best standard minimum of treatment is the administration of 10 grains of

PUBLIC HEALTH NURSING

quinine three times daily for two days, followed by 10 grains twice daily for five additional days. Since quinine reserves are rapidly being depleted, a substitute, totaquina, is being introduced and will soon be available for general use. This agent contains all the important cinchona alkaloids, being composed principally of quinine, quinidine, cinchonine, and cinchonidine. It is at least two thirds as effective as quinine in malaria infections. In the absence of cinchona drugs, atabrine may be used, the standard course of treatment being 0.1 gram, (1.5 grains) three times daily for five to seven days.

EDUCATION

Equally important to the public health nurse's part in the treatment of malaria is her part in educating people in the means of avoiding infection. In vicinities where *Anopheles* mosquitoes occur, her two main problems in connection with such education will be to convince people of the necessity for mosquito-proofing their homes and for staying behind screens in the evening and at night. (Fortunately, there still seems to be a considerable quantity of 16-mesh galvanized wire in the hands of retail dealers.) These two problems can be approached by several means: for example, by pointing out the seriousness of malaria, by dwelling on the probability for an increase in malaria, by describing the various effects of malaria on the individual and his

family, and by explaining the methods of transmission.

Whether her efforts be made in individual cases or whether the approach be through working with organizations in the community who are interested in malaria control—in either case the public health nurse has the opportunity to make valuable contributions to the educational process that is necessary for solution of the malaria problem.

THE OPPORTUNITY FOR SERVICE

The public health nurse may very well become a keystone in an action program directed toward the control of malaria, for the nature of her work enables her to participate in case-finding, treatment, and educational aspects of such a program. To prepare for this opportunity, she must provide herself with the necessary background of information concerning the region in which she works. Have any studies been made to determine the prevalence of malaria in the community? If so, how much malaria was found and where is it? Are the cases under treatment? What mosquito is responsible for transmission? What educational materials are available for use in teaching the people about malaria? These are some of the questions, the answers to which will provide at least a few threads with which to weave a pattern of protection against a menace that could very well become a health problem of the first magnitude.

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Driving Cars in Wartime

BY DOROTHY E. WIESNER AND MARGARET M. MURPHY

EARLY in 1942 the Office of Price Administration telephoned the National Organization for Public Health Nursing for an estimate of the number of cars being driven by public health nurses. This information by states was wanted within 24 hours. From data previously assembled at headquarters we estimated that the 24,000 public health nurses in the United States were driving some 12,000 cars.

The last N.O.P.H.N. transportation study was based on 1936 data.* The 1942 Yearly Review included several questions about transportation, one being, "What plans for adjustment of transportation have been made because of war regulations affecting the use of automobiles?" This review summarizes replies from 579 agencies, about 9 percent of the total public health nursing agencies in the country.

Use and Ownership of Cars

All but 24 of the 579 agencies reported that their staffs used cars. Of 232 non-official agencies in the sample, 98 percent used cars; 90 municipal health departments, 97 percent; 101 county health departments, 100 percent; 140 departments of education, 89 percent; and 16 combination agencies, all but one agency.

It was more usual for the nurses than the agencies to own their own cars. This was particularly true in the county health departments and in departments of educa-

tion, over three fourths of such agencies reporting nurse-owned cars. In non-official agencies, 33 percent of the agencies reported all nurse-owned cars; in 40 percent, some nurse-owned and some agency-owned cars, a much higher proportion than in health or education departments. The smaller nonofficial agencies, with 2 to 15 nurses, were more apt to use nurse-owned cars than were the larger agencies.

Among the 579 agencies, 3,807 cars were reported in use, of which 80 percent were nurse-owned and 20 percent agency-owned. In these agencies, 8,639 nurses were employed. Thus this sample showed 44 cars for each 100 nurses.

Methods and Amounts of Reimbursement For Nurse-Owned Cars

The most usual way of reimbursing a nurse for driving her own car was to pay her a flat monthly sum, 41 percent of the agencies using this as the only method of reimbursement. Mileage only was paid by 30 percent of the agencies. A combination of flat rate and mileage was paid by 8 percent of the agencies. Other ways of reimbursement included supplying gas and oil for agency work, or paying the equivalent of bus fares.

Among the agencies that reimbursed the nurses on a flat monthly basis, 66 paid less than \$25 a month, 44 paid \$25-\$29 a month, and 51 paid \$30 or more a month. There were 25 others that paid flat allowances, but varied the amounts according to the nurse-driver's position on the staff, or the season of the year.

*Miller, Anna J. "Use of Cars By Public Health Nurses." *PUBLIC HEALTH NURSING*, March 1937, p. 157.

PUBLIC HEALTH NURSING

County health departments paid a higher monthly reimbursement than did other kinds of agencies, as might be expected because of greater mileage necessary. The median amount for such agencies was \$44. Departments of education reimbursed at lower rates, the median amount being only \$16.

More than half of the 136 agencies that reimbursed on a mileage basis paid five cents a mile. Only 29 paid more than five cents, the highest rate being ten cents a mile. Seven paid less than four cents. In 9 agencies there were variations, such as payment of higher mileage for the first 100 or first 1,000 miles, and decreasing the rate as mileage increased. Some agencies stated maximums or minimums in connection with mileage rates.

Yearly Mileage per Car

Another transportation question was, "What do you estimate to be the total yearly mileage for agency work of all automobiles?" This was answered by 380 agencies who gave also the number of cars used. Among the 380 agencies, 42 percent showed an average of less than 5,000 miles, and 46 percent an average of more than 6,000. The median mileage was 5,649. Departments of education showed low mileage, the median number of miles being 3,900. Average mileage in nonofficial, combination and municipal health departments was near the median, in the 5,000 to 5,999 range. County health departments showed much more mileage, 76 percent of the cars being run for 6,000 miles or more. The median number of miles was 8,579 for county health departments.

Plans for War Adjustments in Transportation

Ninety-eight of the 555 agencies using automobiles reported plans to save mileage. Many were concerned with reviewing the work of the agency in view of

transportation problems, wording their replies as "more careful planning of work," or "redistricting areas to save automobiles." Increasing the use of public transportation was an economy measure mentioned frequently. Sharing cars with other workers and agencies was suggested by 14 agencies, 8 being county health departments. Eleven believed they could reduce the number of home visits, and 6 of these—all county health departments—planned to substitute clinic and conference service for home visits. Six said they would use volunteers for driving the cars, each volunteer providing transportation for a group of nurses. Cutting down on transporting patients to clinics, mentioned by three nonofficial agencies, is a saving of time and expense long recommended. Making fewer visits to schools was mentioned by one county health department, and another worded their suggestion, "asking school personnel to request home calls only when necessary and to screen requests carefully." The value of informing the public as to when to call in for service was stated as helpful in saving transportation. The increased use of the mail for quarantine placards and of telephones and mails for routine queries was suggested. One combination agency said their nurses were given passes on city buses in return for industrial nursing given employees of the traction company, but did not state the amounts involved or whether this seemed a fair exchange of values. Another nonofficial agency had arranged with the Police Department to take nurses to and from night calls.

Rationing Board Experiences

Three of the replies indicated differences in rulings by local rationing boards. One Indiana agency reported that the purchase of two new cars and some new tires for nurse-owned cars had been approved. A Georgia agency reported that their nurses would not be able to purchase

DRIVING CARS

new tires, and a California agency that their rationing board required that 95 percent of the mileage on nurse-owned cars must be for V.N.A. duty. It may be mentioned that rulings in relation to the purchase of automobiles and supplies in most areas are favorable to public health nurses. Published interpretations from the Office of Price Administration are helpful in this connection.*

How Many Cars for Public Health Nurses?

When the estimate was sent to the Office of Price Administration in January 1942, the data outlined on these pages had not been collected. The 1942 study verified our estimate of 12,000 cars in use

by public health nurses. For when we applied the number of cars per 100 nurses in each group of employing agencies to the total number of nurses in similar agencies in the United States, as shown by U. S. Public Health Service figures, the total number of cars was estimated to be 13,272. The difference in the two estimates is due chiefly to the fact that the smaller includes cars for only 3,271 industrial nurses, while the larger allows cars for 5,512 industrial nurses as shown by later figures made available in the 1941 National Survey of Registered Nurses.

*"New Cars for Nurses." PUBLIC HEALTH NURSING, January 1943, p. 59. Also: Hilbert, H. "Wartime Economics in the Use of Cars." PUBLIC HEALTH NURSING, April 1942, p. 183.

TRAVEL TIME AND COST STUDY

A FIRST step in placing the Taunton Visiting Nurse Association on a war-time basis was to make a study of transportation time and costs. We have a staff of five nurses for whom we have two cars. Our city of 37,500 covers 50 square miles, with a thickly populated central area and a large rural area practically surrounding it. There are several bus lines but they are little use to us, because they do not reach the territories we cover, the schedules are inconvenient, and when overcrowded the buses do not stop.

Our president appointed a committee of four to study the situation. They secured a large scale mounted map of the area. Visits for two days were marked with colored pins, a different color for each nurse. These were connected with blue twine representing one day's travel and white, the second. Two days' records took all our space so we stopped there. In addition to the map record we kept

careful account of mileage as well as travel time.

Even this limited study showed what we really knew but failed to remember—that we were making daily visits to patients far from the center of the city, using an undue amount of nurses' time as there were no other visits a large part of the way. Our findings although modest were stimulating and we plan to repeat the study at regular intervals. We found that: (1) One nurse was walking too far (2) The boundary of one district should be changed (3) It paid to have two nurses working in the same district at the same time (4) Cars had been used for driving distances of only one and two blocks, when neither time nor energy was saved. All of these situations have been corrected.

—MRS. THOMAS J. ROBINSON, *Director*
TAUNTON VISITING NURSE ASSOCIATION
TAUNTON, MASSACHUSETTS

What the Industrial Nurse Can Do about Tuberculosis

By FLORENCE E. MACINNIS, M.D.

SEVERAL FACTS are necessary to a full knowledge of what the nurse in industry can do about tuberculosis.

Tuberculosis is a germ disease, caused by a microorganism, the tubercle bacillus. It is an infectious disease. Every case comes from another. It is still among the leading causes of death.

Tuberculosis may exist during any age period. A brief consideration of the ages at which death from tuberculosis occurred among males and females in Milwaukee during 1941 will bring this fact to light.

Most deaths in childhood occurred under five years of age. Overwhelming disease in the form of miliary tuberculosis involving most or all organs, or tuberculous meningitis, account for these deaths.

From the age of five to the teens, few deaths occurred. In the teen age the rate of death is higher among girls. This is true until the age of 35, when the deaths among men begin to markedly outnumber those among women. The death rate remains higher among men through the age of 65. After this time, the numbers are fairly equal.

One hundred and forty-one men died—twice the figure 69, the number of women who died.

The importance of tuberculosis in industry looms high when we are faced with figures which show a high death rate in women from 15 to 35 and among men from 35 to 65—the years for each sex when they are most likely to be employed.

The discovery of tuberculosis in early stages brings about greater and faster probability of cure. To now, unfortunately, 80 percent of sanatorium patients begin treatment when the disease is moderately or far advanced. The insidious nature of this disease, which so often progresses without making its host conscious of its presence, is a partial explanation for this fact.

When tuberculosis exists, if proper search is made, it may be found. The aids to a diagnosis of tuberculosis are:

1. History of the possibility of contact with tuberculosis.
2. Tuberculin skin test.

(a) Mantoux—intradermal test is done by injecting a known quantity of a solution of Old Tuberculin or Protein Purified Derivative into the outer layer of the skin.

The mantoux test is inspected in 48 hours. A raised reddened area, or positive test, indicates only that tuberculosis germs have been taken into the body.

A negative test usually means no tuberculosis. There are occasional incidences of negative tests in the presence of tuberculosis. All of these are not explainable. Where the individual tested has a history of exposure or suspicious symptoms, he should be checked further in the same manner as the reactor.

3. An X-ray of the chest is the next step. A well-taken roentgenogram interpreted by a physician trained in the reading of chest X-rays is the most important

INDUSTRIAL NURSE AND TUBERCULOSIS

aid in the finding of tuberculosis. X-rays, however, show shadows only. From shadows alone one cannot always determine whether the disease is active.

4. Careful physical examination of the chest is the next aid.

5. Sputum, blood, and temperature studies will help in the determination of the status of the disease.

With these basic facts in mind let us consider the tuberculosis problem which faces the nurse in industry today.

War always brings forth significant rises in tuberculosis rates. Tuberculosis among the armed forces during the last war has cost the Government of the United States \$960,000,000. To avoid this in the present war, Selective Service is doing its part in early diagnosis. Definite dicta have been laid down to bar men and women from service on chest X-ray evidence. Those who are rejected should have adequate study to determine their status. Many of those rejects are already working or will be applying for work in the war industries.

Vigilance on the part of the nurse will lead to correct diagnosis and solve the problem of adequate observation and care of these individuals. Some are able to work on a full-time basis; others, while noninfectious, are able to do only limited work. Many are definitely ill and should be hospitalized.

Industry has been on the alert for tuberculosis. Many industrial plants have installed their own X-ray equipment. In these, preemployment X-rays are mandatory. Others have made use of private X-ray facilities. In some instances all prospective employees are X-rayed. In other cases, the nurse plays a large part in picking those who should have films. Some industries use the tuberculin test routinely prior to employment and depend upon private or public facilities for roentgenograms and other study.

In Milwaukee, the Tuberculosis Division has been called on constantly during the past year to help to decide yes or no for a prospective employee in industry.

Recently, the Committee on Industrial Tuberculosis of the American Trudeau Society, in a report on tuberculosis among employees of hospitals, projected a plan which should be helpful in industry. This plan includes preemployment examinations and periodic examinations during employment. It is as follows:

Preemployment examinations:

1. A history record with specific reference to previous tuberculosis contact.
2. Mantoux test with standardized tuberculin properly applied and interpreted.
3. A chest roentgen examination satisfactory to a critical expert.

Periodic examinations during employment—according to the results of the preemployment examinations, applicants should be divided into three groups for which the recommendations for subsequent periodic examinations differ:

Group A—Those tuberculin negative on employment. Tuberculin test should be repeated every three months. (Every six months may be sufficient in an industry where there is no special tuberculosis hazard.)

Those who become tuberculin positive while employed should be kept under careful clinical observation for at least two years—with repeated chest roentgen examinations; they may then be transferred to Group B.

Group B—Those tuberculin positive on employment but no history or roentgen evidence of significant tuberculosis. Roentgen examination should be repeated at least once a year.

Group C—Those with recorded history of past tuberculosis or evidence of arrested tuberculosis on employment. Ex-

PUBLIC HEALTH NURSING

aminations should be made in accordance with the history and findings.

Preemployment discovery of active tuberculosis in an applicant means that companies will avoid paying compensation or sick allowance to that individual when such payment would not be chargeable to the industry.

Periodic examinations are also important. Discovery of tuberculosis in early stages means shorter duration of the disease and a lower death rate—profit to employer and employee.

Periodic tuberculin testing of negatives will result in:

1. Early case finding.
2. Decreasing roentgen examinations.
3. The provision of a sensitive index of where and when infections are occurring.

The nurse in industry who is familiar with the basic principles of tuberculosis and with this plan is in a key position to make a big contribution to tuberculosis control. In plants where no tuberculosis facilities exist, the nurse who knows her employee, who has taken an adequate

medical history, can find some way to have him examined thoroughly.

The nurse in one Milwaukee industry, which employs about 1,000 men and women, by taking a good history promoted the discovery of six cases of tuberculosis in six months. This was followed by a survey of the entire plant in which all employees were X-rayed. Five additional cases of tuberculosis were discovered. The X-rays were done in the photo-fluorographic trailer unit of the Wisconsin Anti Tuberculosis Association. Now that all of the employees have been checked, all prospective employees with a history of possible contact are required to have a tuberculin test and if positive, a chest roentgenogram.

This is just one example of what has been done. Similar stories may be told of the nurses in many industries. Corresponding opportunities are open to every nurse in industry.

From a talk delivered before the National Safety Council's 31st Annual Safety Congress, October 28, 1942, Chicago, Illinois.

THE AMERICAN JOURNAL OF NURSING FOR MAY

Congestive Heart Failure.....	Paul D. White, M.D.
Fiftyish and Refreshed.....	Matilda Davis, R.N.
Nursing Service in a Small Plant.....	Hazel H. Leedke, R.N.
Nursing in Latin America.....	Yvonne Hentsch
Army Nurse Wins Air Medal	
How to S-t-r-e-t-c-h Uniform Fabrics	
Visual Education in the Navy.....	Jean Byers, R.N.
Central Schools for Rural Areas.....	H. Lenore Bradley, R.N.
College Students in Nursing	
Recent Drugs: A Review.....	Windsor C. Cutting, M.D.
Some Types of Volunteer Service	
Russell Traction.....	Carmelita Calderwood, R.N.
Uncle Sam Provides Obstetric Care	
USPHS Nurses in War Activities Areas.....	Anna Heisler, R.N.
A School of Nursing Faculty.....	Laura R. Logan, R.N.
Social and Health Aspects of Nursing	

Chest - Proofing the Payroll

By ADELE B. SCHOOF, R.N.

MANY TIMES I have been asked, "Do you think chest examinations are important in industry?" My answer is, "I do." I have thought them of prime importance for a long time, but my belief was based largely on faith. Our experience of the past two years, however, has proved exactly how important this type of examination is.

The plant in which I work employs at normal times something over 1,000 workers in predominantly heavy and unskilled jobs. Over 80 percent of the employees are men, and of these approximately 20 percent are Negroes and Mexicans. The total also includes a relatively large proportion (about one-fifth) of men and women born in eastern and southern European nations with normally high tuberculosis rates. With the population shifts of the last two years, many of our jobs are now filled by semi-migratory white workers from southern states—again a factor to be taken into account in considering our tuberculosis hazard. The average age is 33; slightly over half are under 30, but our employee rolls include many workers above 50.

Bearing these population factors in mind, particularly the high tuberculosis rates shown by surveys to exist among unskilled labor, we have tried during the past two years to carry through a tuberculosis case-finding program that would eliminate the disease as far as possible from our plant. This program has taken two directions.

First, since facilities for a more am-

bitious and scientific program were not then available, we worked out a simple medical-social history form called a "Health Application." One of the questions asks whether the applicant ever had any contact with tuberculosis, another whether he has ever had pleurisy, pneumonia, asthma, bronchitis, loss of weight, or frequent colds.

During the first six months of 1941, as a result of this questionnaire form, five active cases were picked up. Whenever a history of contact was given, the applicant was sent to the Wisconsin Anti-Tuberculosis Association or the Tuberculosis Division of the Milwaukee Health Department for a tuberculin test and if positive, an X-ray.

THE striking findings in this preliminary screening of our employees led to the second and more ambitious phase of our case-finding program. In the summer of 1941 the Wisconsin Anti-Tuberculosis Association inaugurated its 35 mm. photo-fluorographic X-ray program in industry and we were among the first plants to avail themselves of this service. While we do not have a full-time plant physician, we have a physician on call who was consulted. He heartily approved the proposed program. The trailer unit was therefore brought to the very doors of the factory. Each day certain departments were examined. By this system the workers moved to the unit in a steady flow and the plant foremen knew exactly where their people were. The capacity of

PUBLIC HEALTH NURSING



Workers move to the trailer unit
for X-rays in a steady flow

this new type of equipment is such that films were taken at the rate of about 250 per day. The examining phase of the project was therefore complete in four and one-half days.

Much to our surprise we had 100 percent response, or a total of 1,111 films. This gratifying response was due in part, I think, to the preliminary educational work done with both management and labor, particularly with the plant foremen. It was due in part also to the fact that our industrial nursing program has been in operation for many years and the workers therefore have had an opportunity to learn to know and trust it. Another particularly important factor in the program's success was the assurance to each worker that the report of findings would be given to him rather than to the company, and the company's assurance that workers who might have to quit their jobs because of tuberculosis findings would have these jobs back after recovery.

Each employee received a written report of the findings of the miniature film. When further study of his condition was suggested a report was sent to the family

physician. In 49 instances, or approximately 4 percent of the 35 mm. films taken, recommendations were made for 14 x 17 films. The total 35 mm. X-ray findings, compiled by the Wisconsin Anti-Tuberculosis Association, were as follows:

Essentially negative	937
Primary tuberculosis	110
Unsatisfactory for reading	15
Recommended for 14 x 17 films	49

Classified on further study, as follows:

Essentially negative	23
Pulmonary tuberculosis, moderately advanced, active, recommended for sanatorium care	3
Pulmonary tuberculosis, probably inactive, or diagnosis incomplete	6
Suspicious pulmonary tuberculosis, healed	2
Primary tuberculosis, inactive	2
Pulmonary infection, non-tuberculous	4
Bronchitis	1
Failed to report for 14 x 17 film	8
Total Employees Examined	1,111

Two of these 14 x 17 plates were taken and read at the Milwaukee Health Department, the others at a local Milwaukee hospital. Laboratory work was also done when indicated, including sputum examinations, gastric examinations, and guinea pig inoculations. Reports on these follow-up studies were sent to the family physician.

ALL in all, 11 individuals were found with reinfection tuberculosis, one percent of the total number. Of these 11, three cases of unquestioned activity were found, all of whom were admitted to the county sanatorium for treatment. Two other cases which would probably have been advised to enter the sanatorium terminated their employment before completion of study.

These findings may appear to be low. It should be borne in mind, however, that they represent the second phase of

CHEST-PROOFING THE PAYROLL

our project. During the first phase, the preliminary screening by means of the medical-social history, five persons were rejected for employment. In all then, eight active cases were found or approximately seven tenths of one percent, a morbidity rate twice that to be expected in a normal Milwaukee population sampling according to statistical estimates.

The value of this program has not been confined to the plant itself. The three workers who entered the sanatorium as a result of their X-ray plates had had no previous symptoms or contact with tuberculosis as far as they knew. Their families were visited and arrangements made for examination of all contacts. Many other workers were so impressed by the program that they asked where they might take their families for similar diagnostic tests.

Another essential part of the program is the plant follow-up. On some of the

presumably inactive cases, recommendations were made for periodic follow-up films and these are routinely arranged for. Before such employees are permitted to resume work they are required to produce a statement from their family physician certifying as to their ability to resume work, and the type of work to be permitted. In some cases the man's work has to be changed.

As new people are interviewed for employment, inquiry is made as to whether they have previously been tuberculin tested or X-rayed. Signed statements are obtained giving the industrial nurse permission to obtain a copy of the findings. If re-examinations are necessary they are sent to the local health agencies. Contacts are routinely examined, and these are a larger group than might be expected. Applicants who are underweight, exhibit poor color, signs of malnutrition, or have frequent colds, also are checked before



When properly approached employers and management alike will cooperate wholeheartedly in a tuberculosis case-finding program for industry

PUBLIC HEALTH NURSING

employment regardless of whether they have had contact. It has been my experience that applicants are very cooperative in accepting a recommendation for examination.

OUR experience in this tuberculosis case-finding project seems to justify certain conclusions:

1. Tuberculosis is present in industry, even when symptoms do not appear to be present.

2. Even when facilities are not available for a 100 percent X-ray check of employees, many cases can be discovered through leads afforded by means of a careful medical-social history taken by the industrial nurse. This is a resource at the

disposal of almost any industrial nurse who has the initiative to avail herself of it, and will take the time.

3. If approached intelligently and treated squarely, employees generally will cooperate wholeheartedly in a case-finding program.

4. The same holds for management. Particularly in defense plants today, tuberculosis can be demonstrated to management as a saboteur which should be eliminated immediately and completely from the plant.

5. The 35 mm. X-ray film, supplemented in a small percentage of indicated cases by the 14 x 17 plate, affords a simple, reliable, and practical method of large-scale industrial case-finding.

DIFFIDENT INVITATION TO A RATIONED DINNER

Will you come to dinner Wednesday?
There'll be very little meat,
There'll be precious little coffee,
And you'll not get it sweet,
There'll be bread already buttered,
Buttered, wisely, very thin,
There'll be artichokes, or cabbage,
And it won't be from a tin.

Will you come to dine on Wednesday,
Though the lights will all be dim,
And there'll be at most one cocktail,
And the hors d'oeuvres few and grim?
We will greet you very warmly,
Though the parlor won't be hot,
And the laundry-man says dressing
Would be simpler if we'd not.

But there'll be some old companions
In old suits and last year's shoes,
There'll be very old French brandy
(Which we'll thank you to refuse).
Come and take pot-luck on Wednesday
While our ration books permit,
Come and share in our privation,
Come and help us eat our bit.

—Irwin Edman.

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The Dysmenorrhea Problem

By NORA WINTHER, M.D.

MENSTRUATION may be defined as the physiological process which periodically prepares the uterus for the implantation of a fertilized ovum. Menstrual flow is the uterine bleeding associated with the shedding of the lining of the uterus in case fertilization does not take place. True menstrual flow depends upon the formation of a corpus luteum. We now recognize anovulatory bleeding or menstrual-like flow, which can apparently also be produced by giving estrogens during the first half of the cycle. The menarche, or onset of menstruation, usually begins between 12 and 14 years of age, but may begin as early as 10 years or as late as 18 years. Before the menarche, girls frequently suffer from dull abdominal pains or cramps, backache, tender breasts, and headache. Normally, menstruation occurs fairly regularly, the typical cycle being 28 to 30 days and lasting four to six days. Normal menstruation should not be accompanied by pain. However, certain physiological disturbances are frequent, such as backache, dull abdominal pain, headache, fatigue, tender breasts and emotional upsets.

HYGIENE OF MENSTRUATION

By and large, the hygiene of everyday life should apply at the menstrual period. Cleanliness is important because of the odors from the menstrual flow which also contains fragments of the endometrial lining of the uterus. Warm baths may be taken throughout the flow providing the menstrual periods are normal. Otherwise

sponge baths should be taken at least once daily. Moderate exercise is also beneficial and frequently lessens menstrual discomfort. However, if the flow is excessive or prolonged, it may be advisable to decrease the amount of exercise until the abnormal condition may be rectified. Swimming is apt to stop the flow in some women. Exercises involving jumping or horseback riding are also deleterious to some. Good bowel habits should be maintained during the menstrual period.

SYMPTOMS

Dysmenorrhea is an exaggeration of pelvic discomfort and other subjective symptoms during menstruation. Of the 7,379 women who entered the University of Minnesota over a four-year period, 20.6 percent complained of menstrual pains severe enough to necessitate going to bed occasionally and 2.6 percent were confined to bed every month.

Intermittent colicky pains limited to the lower abdomen is the most constant complaint. However, leg aches and backache are frequent. Nausea and vomiting may be present indicating an excitability of the vagus nerve. Painful or tender breasts may be due to a cyclic secretion of prolactine. Premenstrual swelling may be due to a decrease of progesterone. Psychological symptoms include a depressed feeling and fatigue. The pain usually begins just before or at the onset of menstruation and reaches its height in 24 hours. This pain is a smooth muscle pain similar to that of gall bladder or renal

stone colic or to the pain in childbirth.

Smooth muscle pain is usually caused by some obstruction. In dysmenorrhea, it may be congenital, that is, women may be born with it, or it may be acquired. In the congenital type, the uterus may be infantile or small, hypoplastic type, or normal size but acutely anteфлекed, (bent acutely forward). In a normal uterus, the lining may swell to such an extent that it acts as a foreign body which the smooth muscle of the uterus attempts to expel during menstruation. The pain may be produced by a chronic pelvic congestion, due to over-exertion, fatigue, constipation, lack of exercise, long hours on one's feet or sitting; or from abnormal sex practices.

Nervous instability of the patient may also be a factor. There appears to be a preponderance of highly sensitive, mentally alert women who suffer from dysmenorrhea, with no demonstrable pelvic pathology. Many of these women are open to suggestion and are frequently cured by bizarre methods. However, the periodic recurrence of severe pain leads to nervous tension and the woman who is a wage earner worries about being incapacitated during a part of each month. The cumulative effect leads into a vicious circle.

Acquired dysmenorrhea may develop any time during the menstrual life of the woman. In this type, the pain is usually not as severe as in the primary type. In fact, it is less intense but of longer duration and frequently more annoying to the patient. The causes of secondary dysmenorrhea include: tubal infection, ovarian tumors, uterine fibroids, displacements of the uterus, or stenosis of the cervix. The closer the uterine fibroids are to the cavity of the uterus, especially in the cervix, the more prone they are to produce menstrual pain. At times these tumors may drop down into the cavity of the uterus like cherries from the branch

of a tree and, as time goes on, they may be forced through the cervix. Narrowing of the cervical os may result from cauterization of the cervix or childbirth, or from operative procedures.

Endometriosis may develop at any time during the woman's life. These endometrial cells are similar in character to those cells which line the interior of the uterus. These cells may wander out of the wall of the uterus, or may be extruded through the Fallopian tubes during menstruation and drop onto the ovaries, the peritoneum over the uterus, or behind the uterus thus causing ovarian cysts and also dense adhesions which may give rise to severe pain. A number of outstanding gynecological pathologists are of the opinion that a certain number of women are born with displaced nests of these endometrial cells which may occur any place in the peritoneal cavity, such as the ovaries, the Fallopian tubes, or even on the appendix.

The infectious type of dysmenorrhea may be due to gonorrhea complicated by infection of the tubes or ovaries, or to abortion with resulting adhesions, or to pelvic tuberculosis.

TREATMENT

A profusion of articles have been written on the treatment of dysmenorrhea by enthusiastic authors, indicating that obviously there is no specific cure. Space will not allow for a detailed discussion of these. For example, the amount of sugar in the blood has been investigated regarding its influence upon menstrual pain, some authors reporting good results by giving sugar (carbohydrates or glucose) and others reporting equally good results with insulin which decreases the blood sugar. Likewise, there is a controversy between the importance of good posture which was advocated by Cunningham and others, and the work of Norman Miller in

which he concluded that there was no direct association between posture and dysmenorrhea.

Dilatation of the cervix has been successful in a number of cases, but the results are usually temporary, unless performed repeatedly, which may be accomplished in the doctor's office. Personally, I prefer the Cleland operation of the cervix if the patient will consent to hospitalization. Here, incisions are made in the internal os of the cervix and the uterus is packed for several days. Other operative procedures such as Blair Bell's anterior hysterotomy or resection of the presacral nerves may be done. The latter operation has been very successful but is a major operation and should be done only as a last resort.

Endocrine (gland hormone) therapy has not come to the rescue in the treatment of dysmenorrhea. The ovary secretes an estrogenic or follicular hormone which stimulates uterine contractions, and progesterin or corpus luteum hormone which decreases uterine contractions. The giving of progesterone should logically lessen the pain during menstruation. However, the hypodermic injections of progesterone are very expensive and the results have not been consistent nor permanent. We conducted a controlled experiment in its use among a group of patients with primary or essential dysmenorrhea. We took 100 college women with no apparent pathology, who came in because of menstrual discomfort. Half of them received orally active hormone tablets and the other half placebo. We obtained comparable results in both groups, and these results compare favorably with the results reported elsewhere with the use of glucose, insulin, calcium, et cetera. A similar control study was done giving progesterone, orally and by injection. In the last study we assayed the hormone output of estrone, pregnandiol and an-

drogens secreted in the urine in a number of patients and found no variation of levels from the women without dysmenorrhea. We cannot expect, then, that hormone therapy will have any effect on the majority of patients, unless we can demonstrate some hormone imbalance present.

To effect a *cure* for dysmenorrhea there should be no further need of palliative drugs. Following a general physical examination, any focus of infection should be removed. The patient should be given a well-balanced diet with sufficient vitamins, calcium, and iron. She should be instructed to take moderate exercise. Good mental hygiene is also important. When indicated, changes in home environment should be made if possible, with elimination of overwork at school, office, or factory, as well as personality conflicts at work; and adjustment of any unwholesome sex habits. In cases of low basal metabolism, thyroid should be given to the point of tolerance.

It is true that pregnancy cures many cases of dysmenorrhea, but women who are self-supporting are disheartened by the doctors who tell them that that is the only cure, and let them go at that. Antispasmodic drugs, such as atropine sulphate, benzyl benzoate, traesentin, lupex, benzedrine sulphate and calcium have all been used in our group of patients. At the present time, temporary relief has been obtained in most cases with a combination of propradrine or ephedrine hydrochloride with a barbiturate and aspirin. The amounts are varied according to the reactions of the individual.

When dysmenorrhea is severe enough to necessitate bed rest one should consult a specialist in gynecology. Treatment of the acquired type with definite pelvic pathology should be directed to the cause rather than to palliative drugs, and hypodermic injections should not be repeatedly used. It is my experience that with the

PUBLIC HEALTH NURSING

exception of very few women, relief from menstrual symptoms is obtained from simple measures. The underlying condition should be determined by a careful

examination. The time lost from work should be negligible. Good mental hygiene and general health measures are in the last analysis all-important.

CHILDBED FEVER

ON FEBRUARY 19, 1843, Dr. Oliver Wendell Holmes first read his epochal essay, "Contagiousness of Puerperal Fever," before the Boston Society for Medical Improvement. One hundred years later, February 19, 1943, in New York City an all-day Conference on Maternal Health and Child Welfare, sponsored by The New York Academy of Medicine, the Maternity Center Association, Inc., and other cooperating organizations, celebrated this event.

At the time of the essay's first reading, deaths from childbed fever were never less than 10 percent and in some isolated instances as high as 90 percent. In 1942 only about 3,000 mothers of approximately 2,000,000 in the United States died from this cause. However, childbed fever is still the largest single cause of maternity deaths.

At that time, as now, to use Dr. Holmes' own words, "The routinist and unthinking artisans in most callings dislike whatever shakes the dust out of their traditions." The traditions of his time are best expressed in the words of esteemed Dr. Meigs of Jefferson Medical

College. He said, "I prefer to attribute them (the deaths from puerperal fever) to accident and the Providence of which I can form a clear conception, rather than to a contagion of which I cannot form any clear idea."

After a decade of bitter attacks, Dr. Holmes made his last public statement on the subject of this essay. He said (in part) "the character of the opposition which some of these papers have met with suggest that they contain really important truths. . . . If I am wrong, let me be put down by such rebuke as no rash declaimer has received since there has been a public opinion in the medical profession in America; if I am right, let doctrines which lead to professional homicide be no longer taught. Indifference will not do here."

His crusading spirit is expressed in these words, "And for my part I would rather rescue one mother from being poisoned by her attendant, than claim to have saved forty out of fifty patients to whom I had carried the disease."

Pasteur did not prove the existence of germs until 1860.

Newer Aspects of Maternity Care

By LILLIAN JEFFERS, R.N.

MATERNITY CARE today is a different story from maternity care of yesterday—yet, actually it is nothing but a continuation of the same old theme. Babies are born in the same way and mothers' and babies' needs are the same. The simpler life of a half century ago did not exempt mother and baby from penalties when nature's laws were violated, any more than the life of today.

The difference is that today we know more about those laws; we know much better what mothers' and infants' needs are and how to meet them. Medical and nursing science in the past few decades has made great strides in the physical aspects of maternity and infant care. The psychological and sociological phases, though more laggard in development, are catching up. We are beginning in our practices to recognize that good maternity care is something more than highly skilled and scientific attention to the physical side of having a baby.

Our care, hitherto largely a matter of test tubes, pots and pans, sterile areas, and regularity in feeding, has broadened and continues to broaden to an understanding of the mother in her total situation. No longer is the pregnant woman singled out for our whole attention, for pregnancy involves a whole family. There may already be two or three small children whose fortunes will be changed by a newcomer or by the mother's injury or death. Household routines and economics and relationships are dislocated. Good maternity care considers the whole family

as involved in the pregnancy and delivery sequence. Also, present-day thinking does not consider maternity as a matter of just one generation. Maternity is a never-ending process; the unborn child is a potential parent, and the kind of care he gets is perpetuated in his children's children. The poet said, "The child is father of the man." We say the unborn child is father of generations.

The first thing we tend to do when we accept a pregnant woman for care is ask: "Have you seen a doctor? Are you planning to have your baby in a hospital? Have you begun your layette?" When the answers are "yes" we may go on to explain how the baby grows and what to expect during pregnancy; we hand the mother instructive literature. All these are helpful yet they can hinder the patient's progress and actually make her pregnancy harder unless her mental and emotional attitudes are in harmony with her pregnancy. This means there is a variety in degree of acceptance of pregnancy. How does your patient feel about the news that a new baby is coming? Is she secure in her husband's affection, in her faith in her doctor, in her social and financial situation? Has she faith in her own physical ability to carry through? Some women resent pregnancy a great deal. Others may be ashamed. Still others may be serene and happy over the news, because they are confident of affection and meticulous care, and they want their babies. These are but a few of the reactions women undergo when they learn they are pregnant.

PUBLIC HEALTH NURSING

OUR success with our patient and the happy culmination of her pregnancy depend a great deal on our understanding of her readiness for the situation. Understanding of the patient's feelings must be a basis for our procedure. It must include not only comprehension of her feelings toward herself but toward her husband and the children, and their feeling toward her. If maternity education is to be a part of strengthening and integrating family life, the currents of emotion within the family must be recognized and understood as far as a sympathetic nurse can understand them. At least she must know that they are there and must study them in everything she does. Therefore, in approaching a newly pregnant woman, the nurse must be a learner before she can become a teacher. And this learning must go into realms of feeling as well as into tangible facts. In the past we have tended too soon to become the teacher, to instruct this human who obviously needed information, and have tried to have her fit into a plan that seemed to be a good plan for everyone.

Today, happily, we are doing an about-face, recognizing that the teacher learns much from the pupil. In maternity situations this is particularly true. The woman who has undergone the fear and exaltation, the physical pain and sense of aloneness that comes with bringing a new life into the world, has had an experience that must have value to herself and to others. Not all their experiences are good, yet their poignancy seems to give one mother authority to speak to another. Under the guidance of a skilled nurse who knows how to utilize this information, this sharing of experience can be valuable to all.

This idea of teacher and pupil sharing knowledge and learning together is a phase of democratic living. It is an idea that offers great hope to a community and

a world in which we must foster democracy. Certainly as a method it is proving successful in the teaching of mothers. Mothers' clubs in general have been good but we have tended to stand on a rostrum in conducting them. Some of us are still on the rostrum, but others of us are wise enough to make these meetings little democracies where give-and-take occurs in teaching and demonstration. Maternity is an adult experience and certainly the mother with a child has some idea of how to care for him. Each individual brings to the group problems, interests, and needs which can be used as a basis for class activity. The nurse responsible for leading the group must have a broad knowledge of her subject but knowledge alone is not enough. Her relationship with the group should be built on her own deep and kindly interest in people and on her awareness of their varying degrees of readiness for group participation.

As for new physical aspects of care of the mother, frankly I am aware of nothing startling. There are, of course, new refinements of our present knowledge, and additions to it. Outstanding are the studies demonstrating the part an adequate diet plays in determining the successful outcome of pregnancy, as well as its influence on a healthy baby. Every nurse doing maternity work must be keenly aware of the newer knowledge of nutrition if she expects to be helpful to the patient and her family.

Preparation for breast feeding, both physical and mental, is begun early in pregnancy. Today we realize that when the mother is reasonably secure in her surroundings and is able to nurse her baby, breast feeding provides more than physical nourishment. It is a basis for a positive parent-child relationship and gives more security to the baby than any

MATERNITY CARE

other influence in his life can provide.

In many instances elaborate home delivery and other techniques have been replaced by simpler ones which are proving to be equally effective. For example, perineal care is now often regarded as an aesthetic measure. Actually its worth as asepsis is being questioned. Nurses no longer practice for weeks to determine a correct method of diaper folding. Common sense today allows the mother certain leeways and she adjusts the diaper according to the kind of material, the size of the baby, and the way it pleases her.

Many of our ideas of infant care, however, have been greatly modified. From the moment of birth the baby is considered as an individual and is treated as one. He is gently handled and his physical and emotional requirements are studied. No longer is the infant expected to conform to adult standards of sleeping, eating, and elimination. By that I mean that the old pattern of feeding according to a set time and a fixed amount is outmoded. The newborn infant himself by his waking and sleeping habits assists the mother in determining his needs.

Our change of thought further extends to the practice of too early training in the habits of elimination. It is now recognized that when these processes are allowed to function normally they are sources of satisfaction and pleasure to the infant. The parents' acceptance of this fact is a preparation to aid in training the child when he is physically and emotionally ready for it. Given the opportunity, parents prove their ability to interpret the various stages of growth and development of their children. This understanding enables parents to derive deep pleasure from their experiences. Nurses today rendering an adequate maternity service must have a thorough-going knowledge of all phases of child care.

No discussion on maternity care is complete without reference to the fact that there exist areas in our country in which 95 percent of the babies are born at home and receive no nursing care during any phase of the maternity cycle. With many of our doctors called to the armed forces, this presents a more serious problem than ever and deserves our first consideration.

There are many new problems in maternity care: the pregnant woman with a husband in the army, the mother faced with the care of her children while their father is at war, increased financial insecurity of war families, inadequate housing conditions around military and industrial centers, pregnant women working in industry. Some of these problems are age-old, but they are receiving new emphasis because of the present upset world.

The perpetuation of the race goes on and on. The protection of those who give birth and those who are being born is society's greatest obligation. We have moved through various cycles in discharging this obligation. The carefully developed physical care that science has provided in recent decades is being augmented by attention to the sociological and psychological factors that are equally important. The family itself and its readiness to accept the new pregnancy is an important factor in our newer concepts of maternity care. Also we are recognizing the importance and dignity of parents and their part in the social order. It has long been stated that family education in broadest terms is the basis of our public health work. If this is true, we have only begun to scratch the surface in giving care to mothers and babies.

Presented before the N.O.P.H.N. Round Table on Maternal Care, Biennial Convention, Chicago, Illinois, May 21, 1942.

Home Care of Crippled Children

By ALICE MILLER, R.N.

STATISTICS show that the handicapped child spends 94 percent of his reconstruction period in the home.¹ If home care is inadequate through the lack of proper interpretation and supervision, the 6 percent of time spent in the hospital may well be lost.

The importance of meticulous attention to small details in home care of the handicapped child has long been recognized by national leaders in orthopedics and pediatrics.

Dr. Arthur Steindler, head of the Department of Orthopedic Surgery of the State University of Iowa, has made this statement²—which might well be applied to every type of crippling condition in children:

I firmly believe the campaign waged in the interest of the cripple should make a major feature of the systematic instruction of the laity in the principle and in the technique of home care; for no particular group is this more important than for the tuberculosis cripple. This should also be greatly welcomed by the general practitioner, because it establishes connection between him and the patient by means of instructing parents and friends in the supervision of his care. It would fill a now existing gap.

Solicitous observation and intelligent and

painstaking care at home, if at the disposal of the patient, will give him the best possible chance for recovery.

Parents or friends of the patient must first be taught what to observe and instructed in the interpretation of their observations; secondly, they must be given some idea of the principles underlying every detail in the management of the cripple at home; and thirdly, they must be instructed in the technique of applying these details.

HOME NURSING FOR HANDICAPPED CHILDREN

At the very beginning of the program by Iowa State Services for Crippled Children it was realized that in order to improve the home care of handicapped children in every county in Iowa, a program for direct and indirect nursing service must be developed for the child in his community. Direct service was provided by interpretation of home nursing problems through the field staff of the State Services for Crippled Children to local public health nurses when available, or directly to parents. This service, because of the size of the territory, was limited.

In October 1941, a program was set up to provide indirect public health nursing service to handicapped children being hospitalized or treated in the out-patient clinics of the Orthopedic and Pediatric Departments of the University Hospitals. A public health nurse with special training in orthopedic and pediatric nursing was assigned to these departments. The success of this service was made possible through the splendid cooperation of the personnel of the Orthopedic and Pediatric Departments, the Medical Social Service

¹ From a paper, "The Problems of the Home Care of Crippled Children," read by Dr. Arthur Steindler before the Thirty-fourth Annual Convention of the Iowa State Association of Registered Nurses, October 1937.

² From a paper, "Home Care of Tuberculosis in Bone and Joint," read before the National Society for Crippled Children, Dallas, Texas, October 1939.

HOME CARE OF CRIPPLED CHILDREN

Department, the Physiotherapy Department of the University Hospitals of the State University of Iowa, and the Public Health Nursing Service of the State Department of Health.

INDIRECT SERVICE

The following is an outline of the indirect service developed for the guidance of the field nurses of the State Services for Crippled Children and local public health nurses, in the care of orthopedic, diabetes mellitus, and rheumatic fever patients who receive treatment and out-patient care at the University Hospitals.

Since the State Services for Crippled Children's agency is housed in the same building with the Orthopedic and Pediatric Departments of the College of Medicine in the University Hospitals, there is close contact with patients and easy access to medical records.

Patients are transported to and from the hospital by a fleet of ambulances maintained by the University Hospitals. These ambulances go to all parts of the state discharging patients on the outgoing trip and bringing in new cases on the return trip. Patients financially able are encouraged to provide their own transportation.

The hospital provides beds for patients requiring treatment in the Orthopedic or the Pediatric Department or both. The out-patient clinics make available routine repeat examinations, X-rays, change of casts, instructions in physiotherapy, and necessary shoe corrections and appliances.

The parent of a child suffering from diabetes mellitus or rheumatic fever accompanies the patient to the hospital to give information regarding the interval history and to receive detailed instructions regarding continued home care. The orthopedic patient, on the other hand, because of the large caseload being transported by hospital ambulances, comes to

the hospital or clinic without his parent except at the time of the first visit, or when the child will need specific detailed physiotherapy treatments at home, as in the case of poliomyelitis. This particular situation leaves much to be desired in furnishing parents and local public health nurses with information necessary to provide the child with adequate home care after leaving the hospital or clinic.

Patients are brought to the University Hospitals from the 99 counties in the state. Fifty percent of those counties have public health nurses who will supervise the home care of handicapped children along with their other public health nursing services. In the other 50 percent, supervision of home care for their handicapped children is available through the field nurses of the State Services for Crippled Children.

STUDY OF HOSPITALIZED CASES

The public health nurse stationed permanently at the University Hospitals becomes familiar with every handicapped child under 16 years of age who is hospitalized. This is accomplished by making rounds each day with the ward supervisor, reading the medical history for most recent findings and treatment, and discussing with the ward doctor the specific needs indicated for the child's continued home care. If the patients are old enough, the public health nurse may tactfully glean valuable information from them regarding the type of care they receive at home as related to diet, use of appliances, performance of exercise routine, or whatever type of treatment is to be carried out at home. Social conditions which tend to complicate the child's home care are brought to the attention of the Hospital Medical Social Service Department. They assist the local social agency and the field social workers in improving these conditions where possible.

Before the patient is ready to go home, the public health nurse has available all information needed to make a simple interpretation of the child's needs for satisfactory home care. A report is prepared which summarizes the medical findings and treatment given to date. From indications made by the ward doctor, suggestions for continued home care are then stated in a simple but detailed manner according to the type of home care indicated. These suggestions vary with each child, depending on his diagnosis and stage of treatment. If the child needs special exercise routine at home, the physiotherapist will outline the technique involved and this information is incorporated into the report.

REPORT TO LOCAL DOCTOR AND NURSE

If the patient being discharged lives in a county where public health nursing service is available, the report is mailed to the public health nurse to be used as a guide in making a home call, and in giving supervision of the child's continued home care. No reply is requested from the busy public health nurse unless questions arise regarding some detail of the home care which is not clear, or if upon making a home call, the public health nurse finds conditions which will not permit carrying out good home care. In either case, the local public health nurse receives further instructions from the hospital public health nurse on how to proceed in solving the problems.

The family physician receives a duplicate of the public health nursing report with a statement that the nurse has received the report in order that she may be prepared to be of service to him in meeting the problems relating to the home care of the child. The public health nurse is also requested to clear with the family physician before making the home call so that a satisfactory medical disposition

may be assured and that the family physician will approve the type of home supervision being offered his patient.

If the child being discharged lives in a county where public health nursing service is not available, the field nurse of State Services for Crippled Children receives the same type of report and includes that child on her home visiting schedule. The family physician also receives a duplicate of the report. If there are simple but important instructions for continued home care which should not be delayed until our field nurse will be in a given territory, a copy of the suggestions for home care is also given to the Medical Social Service Department of the University Hospitals with the request that they be mailed to the parent with the notice that the field nurse may be expected to visit the home in the near future to give further interpretation of the home care.

CLINIC PATIENTS FOLLOWED UP

A similar routine is carried out on patients being seen in the out-patient clinic. The public health nurse is present at the checkup examination and hears the doctor's findings and recommendations for treatment. An interpretation is made of home treatment indicated by the doctor and if the parents are present the public health nurse is ready to give a demonstration or more detailed explanation of the technique involved. If there is a question as to how well the home care will be carried out, the local public health nurse or field nurse of State Services for Crippled Children receives a report of the clinic visit with suggestions for further home supervision.

If parents are not present at the clinic checkup, the report goes out the same as on cases being discharged from the hospital. In every case the family physician receives a duplicate of the report.

This service has been functioning in

the University Hospitals for 16 months. Statistics show that during 1942, 2,356 reports were prepared and sent to either local public health nurses or to our field nurses for home follow-up. This public health nursing service between the child

in the hospital and the child in the home has improved the type of home care for many handicapped children.

The following is an actual nursing report sent to a county nurse and her reply of home follow-up:

STATE SERVICES FOR CRIPPLED CHILDREN, UNIVERSITY HOSPITALS
IOWA CITY, IOWA

PUBLIC HEALTH NURSING REFERRAL FORM

Patient's name—Jones, Mary
Head of household—Henry
Address—Stone, Abe
Referring physician—C. O. Smith, M.D.
Diagnosis—Bilateral congenital dislocation of hip
Public health nurse—Elsie Smith, R.N., County Nurse

Discharged—11/5/42
Date of birth—3/6/36
Hospital number—X-427
County—Regis
Address—Stone, Abe

Please contact the referring physician before making a home call.

Medical Summary:

This child was first seen at University Hospitals on 9/30/41 but because of measles and mumps at home, treatment was deferred until the infectious period was over. The mother was instructed to see her family physician regarding a safe return date.

The patient was not seen again for a period of 13 months (11/5/42).

Examination revealed a 6-year-old female who weighed only 27 pounds and was 39.2" tall. She was in a very poor state of nutrition. She also had a congenital dislocation of both hips, walking with a typical waddling gait. Because of the patient's general physical condition, no orthopedic treatment could be started.

The patient and the mother were seen by the pediatrician who advised them regarding a diet for the child.

Suggestions for Home Nursing Care:

This child apparently has never had a proper diet. The mother states the child has about a half pint of milk per day, three or four oranges per week, no cod liver oil since she was two months' old. Her appetite is reported to be good. The pediatrician advised the mother on the following:

1. Patient should have 340 units of cod liver oil daily.
2. Minimum of one orange or a tomato daily.
3. One quart of milk daily.
4. Minimum of one cooked egg daily.
5. Meat, potatoes, vegetables, fruits daily.

The mother was not given written instructions as it was believed that verbal instructions would be more satisfactory.

The mother was given a prescription for cod liver oil. Both the public health clinic nurse and the medical social service worker of University Hospitals talked with this mother. No orthopedic correction can be made until the child's general health is in better condition.

Since this case is well known to the county nurse, it would be well to give very close supervision and instruction regarding diet. Will the family be able to provide all the foods necessary to build up this child's nutritional status? If not, perhaps the local social agency will help with obtaining the foods. It would be well to keep a weight chart on this child and send it in with her on her next visit.

The mother indicated that the father might not give permission for surgery in the future. He might be encouraged to see the advisability of continuing with this child's care and make sure she is allowed to return.

PUBLIC HEALTH NURSING

Report from Elsie Smith, County Nurse:

I am writing in regard to Mary Jones of Stone, Abey. Her father is Henry Jones. She is a congenital hip dislocation case. She was sent home from the hospital 11/5/42 because she was so undernourished. Since then I have been trying to help the mother in every way possible to get this child to put on weight. Apparently the mother has put forth no effort whatsoever in trying to improve Mary's condition. I visited them each week and tried to help the mother with her budget and planning, but she and her husband just agree to all one says, but then do nothing about it. I weighed Mary each week. Her weight on 12/15/42 was 28 $\frac{3}{4}$ lbs and on 1/25/42 was 27 $\frac{3}{4}$ lbs. Dr. Smith, their present family physician, has talked with the parents too. He furnished Mary with a quart of milk each day. Apparently her diet consists mainly of milk (furnished by Dr. Smith), cod liver oil (furnished by the county), potatoes, bread, and cake.

I sincerely believe that these parents could feed Mary the proper diet as far as finances are concerned, but I doubt if the mother is of high enough intelligence for anyone to make her understand that a head of cabbage or a can of tomato juice is more important in the child's diet than a jar of mustard.

I have discussed this case with Dr. Smith and Mrs. Brown, county relief director, and we feel that it is useless to go on as we have been.

Would it be possible to take Mary into the Children's Hospital to build her up so she might have her hip condition corrected?

If you have any suggestions that might help me in regard to this case, please let me know.

Reply to Report from County Nurse:

We received your report on Mary Jones and want to thank you for the fine follow-up you have given this patient. I am referring your letter to the Medical Social Service Department of University Hospitals. They will discuss the case with the doctors and no doubt notify you of plans which will be necessary for this child's continued care.

Thank you for calling this to our attention.

One recognizes from the county nurse's report a need for more intensive nursing and social planning. For this reason the case was referred to the Hospital Social Service Department to make arrange-

ments for further hospitalization and at the same time tentative plans for a more satisfactory disposition of the case.

At the time this article was written the case was not completed.

In Memoriam

*How sweet the summer! And the autumn shone
Late warmth within our hearts as in the sky,
Ripening rich harvests that our love had sown.
How good that 'ere the winter comes I die!
Then, ageless, in your heart I'll come to rest
Serene and proud, as when you loved me best."**

—HANS ZINSSER

Word has come to us during past months of the death of these old and valued friends of the National Organization for Public Health Nursing. Many were members, many were co-workers. In their passing all of us have a deep and permanent sense of loss.

Mrs. Arthur D. Baldwin, Cleveland, Ohio. (Lay member)

Mrs. Mary Dodd Bingham, March 25, 1943. East Orange, New Jersey. (Lay member)

Edith Bishop, January 29, 1943. Board of Public Education, Philadelphia, Pennsylvania.

Bertha Emma Bonorden, March 29, 1942. Board of Education, San Diego, California.

Richards M. Bradley, February 10, 1943. Trustee, Thomas Thompson Trust, Boston, Massachusetts. (Lay member)

Mrs. Mary Belle Breece, April 2, 1943. Boone, North Carolina.

Kathryn A. Buhrfeind, October 25, 1942. School nurse, Bayonne, New Jersey.

Dr. C. R. Byrd, Detroit, Michigan. (Lay member)

Mrs. D. D. Casement, November 8, 1942. Manhattan, Kansas. (Lay member)

Dr. Horton R. Casparis, November 11, 1942. Professor of Pediatrics, Vanderbilt University; chairman, Advisory Committee, U. S. Children's Bureau.

Mary Roberts Coles, Philadelphia, Pennsylvania. (Lay member)

Mary Elizabeth Davis, February 10, 1942. New York, N. Y. For many years president of the California S.O.P.H.N.

Mrs. Gertrude Shaw Stowell Davis, May 26, 1942. Public health nurse, Salem, New Jersey.

Norbert Denk, April 16, 1942. Grosse Pointe Park, Michigan. (Lay member)

Dr. M. Louise Diez, April 11, 1942. Director, Division of Child Hygiene, Massachusetts Department of Public Health, Boston, Massachusetts.

Anna M. Drake, March 8, 1942. Cincinnati, Ohio.

Lillian Eckert, April 4, 1942. School nurse, Board of Health, Chicago, Illinois.

Ella Fite, September 28, 1942. Weaver, Alabama.

Dr. S. S. Goldwater, October 22, 1942. Commissioner of Hospitals, New York, N. Y.

Mrs. Edward W. Hall, December 19, 1942. New Brunswick, New Jersey. (Lay member)

Mrs. Allen Hamilton. Fort Wayne, Indiana. (Lay member)

Anna Heistad, December 26, 1942. Chicago, Illinois.

Jane Mary Jones, January 16, 1943. Staff supervisor of the Visiting Nurse Association, Utica, New York.

Abbie Mary Kirk, August 21, 1942. Allegheny, Pennsylvania.

Dorothy Koethen, May 1942. Instructor, Riverside City Schools, Riverside, California.

Alma Elvira Lester, June 14, 1942. Old Saybrook, Connecticut.

Janice Ryer Lewis, May 1942. Staff nurse, San Francisco Health Department, San Francisco, California.

Marie Aurore Michaud, November 8, 1942. Public health nurse, Division of Maternal Health, Waterville, Maine.

Nellie Nash, May 4, 1942. Charleston, West Virginia.

Mrs. John A. Paine. West Newton, Massachusetts. (Lay member)

Nell Patterson, October 23, 1942. Public health nurse, Charlotte (North Carolina) Health Department.

PUBLIC HEALTH NURSING

Mrs. Edgar Pierce. Cambridge, Massachusetts.

Mrs. Gladys R. Pittman, January 13, 1943. Bainbridge, Georgia.

Elsie J. Shinnars, August 9, 1942. Eugene, Oregon.

Fannie Simes, December 9, 1942. Staff of Community Health Association, Boston, Massachusetts.

Ruth Skelly, December 16, 1942. Board of Education, City of Los Angeles, California.

Amy L. Stephenson, September 22, 1942. East Orange, New Jersey.

Elsie E. Stephenson, September 10, 1942. School nurse, St. Louis Board of Education, St. Louis, Missouri.

Mrs. N. G. Symonds. Hinsdale, Illinois. (Lay member)

Graham R. Taylor, August 30, 1942. The Commonwealth Fund, New York, N. Y.

Mamie C. Thompson, April 9, 1942. Madison, Alabama.

Catherine Tuite, March 18, 1942. Supervisor

of school nursing, Bridgeport Health Department, Bridgeport, Connecticut.

Mrs. Laura Knowlton Turner, January 27, 1943. Waterville, Maine. Field representative, American Red Cross Nursing Service.

Mary E. Wadley, October 1942. New York, N. Y.

Dr. Leroy A. Wilkes, November 29, 1942. Executive Secretary, State Medical Society, New Jersey.

Lena Tillou Willey, August 15, 1942. Yonkers, New York.

Dr. Emma A. Winslow, April 9, 1943. Author of studies in public health nursing. Riverside, Connecticut.

Helen Wood. Orange, New Jersey. (Lay member)

Jennie Zimmerman, August 12, 1942. Public health nurse, Amsterdam, New York.

*Reprinted from *Spring, Summer, Autumn* by Hans Zinsser with permission of Alfred A. Knopf, Inc.

Programs of Study in Public Health Nursing

Since 1920 the N.O.P.H.N. has had as one of its functions the approval of post-graduate programs of study in public health nursing. Programs which appeared on the first list in 1920 were in existence for various periods of time before that date. Policies of accreditation have changed during the past 23 years; how-

ever, from 1920 through 1941 approval was considered retroactive for the two-year period prior to the date of official action. Since 1942 this retroactive measure has not applied because, according to the present policy, a program may ask for accreditation before any students have been admitted.

APPROVED PROGRAMS OF STUDY IN PUBLIC HEALTH NURSING JANUARY, 1943*

<i>University</i>	<i>Date of N.O.P.H.N. Official Action</i>
Catholic University of America, Washington, D. C.....	1936
Columbia University, Teachers College, New York City.....	1920
Duquesne University, Pittsburgh, Pennsylvania.....	1938
George Peabody College for Teachers, Nashville, Tennessee	1921
Indiana University, Bloomington, Indiana	1939
Loyola University, Chicago, Illinois.....	1941
Marquette University, Milwaukee, Wisconsin	1940
Medical College of Virginia, Richmond, Virginia.....	1937
New York University, New York City.....	1938

PROGRAMS OF STUDY

(Continued)

<i>University</i>	<i>Date of N.O.P.H.N. Official Action</i>
Richmond Professional Institute, Richmond, Virginia.....	1920
St. John's University, Brooklyn, New York.....	1940
St. Louis University, St. Louis, Missouri.....	1938
Seton Hall College, Newark, New Jersey.....	1942
Simmons College, Boston, Massachusetts.....	1920
Syracuse University, Syracuse, New York.....	1932
University of Buffalo, Buffalo, New York.....	1941***
University of California, Berkeley, California.....	1920
University of California, Los Angeles, California.....	1940
University of Chicago, Chicago, Illinois.....	1940
University of Colorado, Boulder, Colorado.....	1942
University of Hawaii, Honolulu, T. H.....	1935
University of Michigan, Ann Arbor, Michigan.....	1920
University of Minnesota, Minneapolis, Minnesota.....	1920
University of North Carolina, Chapel Hill, North Carolina.....	1942
University of Oregon, Portland, Oregon.....	1921
University of Pennsylvania, Philadelphia, Pennsylvania.....	1936
University of Pittsburgh, Pittsburgh, Pennsylvania.....	1922**; 1942
University of Washington, Seattle, Washington.....	1921
University of Wisconsin, Madison, Wisconsin.....	1941
Vanderbilt University, Nashville, Tennessee.....	1932
Wayne University, Detroit, Michigan.....	1931
Western Reserve University, Cleveland, Ohio.....	1920

PROGRAMS FORMERLY APPROVED BUT NO LONGER ON THE APPROVED LIST

<i>University</i>	<i>Date of N.O.P.H.N. Official Action</i>	<i>Date Approval Discontinued</i>
Fordham University, New York City.....	1932	1941
Ohio State University, Columbus, Ohio.....	1938	1940
Pennsylvania School for Social Service, Philadelphia, Pa.....	1920	1935
University of Iowa, Iowa City, Iowa.....	1922	1925
University of Louisville, Louisville, Kentucky.....	1920	1924
University of Missouri, St. Louis, Missouri.....	1920	1924
University of Texas, Austin, Texas.....	1920	1924
Washington University, St. Louis, Missouri.....	1930	1936

*This list is published annually.

**Discontinued in 1924.

***Retroactive for 1 year only.

Reviews and Book Notes

NURSING—AN ART AND A SCIENCE

By Margaret A. Tracy, R.N., and collaborators.
754 pp. The C. V. Mosby Company, St. Louis.
second edition, 1942. \$3.50.

The present edition of this book has been greatly enriched by the revision of certain sections and by important new additions. As suggested in the Preface, it represents the collective thinking of a group of instructors and supervisors in presenting the fundamentals of nursing practice as it is taught in a modern medical center and as it is practiced in the hospital and in the home.

As in the first edition, the text as a whole reflects an up-to-date point of view both with respect to nursing practice and to education of the student. It stresses those abilities needed by the nurse to function in the community as well as in the hospital and to carry out her responsibilities as a teacher of health. The content is well selected and comprehensive, and following the general plan of the first edition is classified under three major headings—General Considerations (which covers basic principles and procedures involved in the personal care of the patient and his environment); Diagnostic Procedures; Therapeutic Procedures. Revisions and additions are noted in relation to such parts as Housekeeping, Care of Flowers, What and How to Record, Rules of Charting—all of which would seem to contribute to the usefulness of the book. An important supplement in outline form has been added under the third heading of Therapeutic Procedures, giving methods for carrying out commonly used nursing procedures. The authors have recognized that methods will vary, of course, with the institution, but offer this supplement to serve schools and instructors as a basis of comparison

and graduate nurses in any field as a reference. Each chapter is followed with an excellent list of references.

In the opinion of the reviewer, this book is primarily valuable for instructors and students in the basic nursing course, but also has much to recommend its wider use as a reference by graduate staff nurses in hospitals and by public health nurses.

ELIZABETH K. PORTER, R.N.
Philadelphia, Pennsylvania

THE PREMATURE INFANT

By Morris Gleich, M.D. 381 pp. Reprinted from
Archives of Pediatrics, Vol. LIX, No. 1, January
1942. Copyright by E. B. Treat and Company,
Inc., 45 East 17 Street, New York, 1942. \$1.

This handbook is largely a report of the care given to the premature infants at various hospitals in New York City, mainly Harlem Hospital.

In Part I, Dr. Gleich gives a general discussion of the causes of prematurity, the anatomical and physiological characteristics of the premature baby. The obligations of the obstetrician and the pediatrician are aptly highlighted. Part II stresses the importance of breast milk and also includes many formulae, together with diet and vitamin suggestions which should prove very helpful. In Part III, pathological conditions and their treatment are discussed. Part IV includes a detailed outline of the Premature Infant Clinic activities at Harlem Hospital and the instructions given to the mother when she leaves the hospital. Part V is an outline of the techniques and routines used. In Part VI, we see that the author has a very keen realization of the fact that the responsibility and care of the premature baby must continue after its discharge from the hospital.

BOOK NOTES

This book should inspire the personnel of public health nursing organizations and hospitals further to improve the care given to the premature baby and thus decrease infant mortality.

EVELYN C. LUNDEEN, R.N.
Chicago, Illinois

INFANT AND CHILD IN THE CULTURE OF TODAY

By Arnold Gesell, M.D., and Frances L. Ilg, M.D., in collaboration with Janet Learned, M.S., and Louise B. Ames, Ph.D. 399 pp. Harper and Brothers, New York, 1943. \$4.

A new book from the Yale Clinic of Child Development is always an event. This one comes most opportunely in the midst of so much planning for day care of children whose mothers are in war work. The style is not as technical as that of some of the Yale Clinic books, nor is it as liberally sprinkled with Dr. Gesell's million-dollar words, and so it is going to be extremely useful in training all sorts of custodians of children. It is a book which should be in every nursing school library and on the reading shelves of every public health nursing unit which includes children in its program.

The volume is divided into three parts, the first dealing with concepts of growth and the adaptation of the child to his environment. The second part takes the child at frequent age intervals from before birth to five years. At each age level, the child and his behavior are so graphically described that the reader develops an understanding of the growing personality. This leads directly into the third part which deals with the guidance of growth at home and in the nursery school.

The underlying philosophy demands a thoughtful study of each child's personality and adaptation of the program to his changing needs. No more can the nurse decide that she believes in a four-hour schedule of feeding and insist that every

baby be forced into such an inflexible plan. Instead of that, she will study the child and the home, and endeavor to assist the mother in planning the sort of day which will combine enough of ritual to give security with enough flexibility to meet the needs of the growing personality.

DOROTHY ROOD, R.N.
Pittsburgh, Pennsylvania

NURSING CARE OF COMMUNICABLE DISEASES

By Mary Elizabeth Pillsbury, R.N. 604 pp. J. B. Lippincott Company, Philadelphia, sixth edition revised 1942. \$3.

This is the sixth edition of a widely used textbook for nurses, which has proved to be a valuable reference on the etiology, history, occurrence and course of various communicable diseases. Although control and treatment practices are changing frequently, and it is difficult to keep material up to date, it is regrettable that a recently revised book on communicable disease should contain a number of statements which are questionable in the light of accepted practices today. For example, page 131—"Disinfection of rooms by gases is being done at the present time in many of our cities both in homes and in institutions. The two gases used are preparations of formaldehyde and sulphur;" page 209—"Care of the linen where patient has chickenpox— . . . in the home, boiled 30 minutes then washed;" pages 460 and 461—Syphilis—"The disease may also be spread by indirect contact; *i.e.*, drinking from contaminated cups or glasses. . . . The disease is considered capable of being transmitted during any stage, but especially while there are any open lesions of the skin or mucous membrane;" pages 488-490—Tuberculosis—"Heliotherapy, natural or artificial, is used by many in treating pulmonary tuberculosis. The affected lung may be given a period of rest

by artificial pneumothorax. [This is the only mention of surgical treatment of pulmonary tuberculosis.] . . . open air schools should be provided for the tuberculous school child."

These and other questionable statements apply rather specifically to current practices of communicable disease with which public health nurses are concerned. It is unfortunate that a book which has so much value as a comprehensive text should be marred by these discrepancies. For future revisions, it is suggested that there be closer collaboration of the author with public health authorities who are responsible for communicable disease control. In the light of this, the book should be used with discrimination.

ALYCE ROONEY, R.N.
Lansing, Michigan

OPPORTUNITIES FOR THE PREPARATION OF TEACHERS IN HEALTH EDUCATION

By Earl E. Kleinschmidt, M.D. 117 pp. Bulletin 1942, No. 1, U. S. Office of Education, Superintendent of Documents, Washington, D. C., 1942, 20c.

This is a survey of courses in health education for teachers in 20 teachers colleges and offers a clear-cut explanation for the failure experienced by many school health services in making the service an integral part of the educational experiences of the school child. While the study presents the status of teacher training for health education, it implies existing inefficiencies in present school health programs.

The findings of this study should be of interest to school administrators and school health personnel alike in helping them to understand the full intent of an effective school health program and why full achievement is so rare. The recommendations of this report, if put into action would necessitate a critical review of the preparation of all school health personnel and their role in the school health program.

B. B. R.

HEALTH FACTS FOR COLLEGE STUDENTS

By Maude Lee Etheredge, M.D. 379 pp. W. B. Saunders Company, Philadelphia, fourth edition revised and reset, 1942. \$2.25.

This fourth edition has been revised to give more material on nutrition, the new drugs, blood banks, and an expanded treatment of relations between the sexes. The author has attempted to cover "the health needs of the present emergency," but comparatively little attention is given to public health and problems of providing medical care to groups—both of which are acute problems at the present time. The book is written in a rather elementary style for college students and probably does not go far enough in answering a student's most perplexing questions. The health rules are common-sense ones, but the average college student is not much interested in precepts. While the book covers the daily practices of healthy living in an adequate manner, there is nothing to distinguish it from many other similar books covering the same topics. It might be of more interest to high school students than to the college age group. Illustrated with diagrams, photographs, and tables.

MRS. JANE F. McCONNELL
San Francisco, California

WHEN DOCTORS ARE RATIONED

By Dwight Anderson and Margaret Baylous. 255 pp. Coward-McCann, Inc., New York, 1942. \$2.

Wartime procedures for the effective procurement of medical, nursing, and hospital services, and for the maintenance of personal and public health, are ably described in an interesting manner in this excellent book. As director of public relations, Medical Society of the State of New York, and therapist, Charleston (W. Va.) General Hospital, respectively, the authors had access to much cogent data, which they present in a logical, useful, and entertaining way. The book is

well printed, but has no index. It is commended to all nurses, both for their own information, and for recommendation to their patients.

JAMES A. TOBEY, DR.P.H.
New York, New York

RECENT PUBLICATIONS AND CURRENT PERIODICALS

GENERAL

PROCEEDINGS OF THE NATIONAL CONFERENCE OF SOCIAL WORK. Columbia University Press, New York, 1942. 670 pp. \$5.

Selected papers, 69th Annual Conference, New Orleans, Louisiana, May 10-16, 1942.

SOCIAL WORK YEAR BOOK—1943. Edited by Russell H. Kurtz. Russell Sage Foundation, New York, seventh issue, 1943. 764 pp. \$3.25.

STANDARDS OF CHILD HEALTH, EDUCATION, AND SOCIAL WELFARE. U. S. Children's Bureau Publication No. 287. Superintendent of Documents, Washington, D. C., 1942. 21 pp. 10c.

DENTAL HEALTH

AN EVALUATION OF DENTAL HEALTH LITERATURE. Vern D. Irwin, D.D.S., and Netta W. Wilson, M.A. Bruce Publishing Company, St. Paul, Minnesota, 1942. 58 pp. 50c.

FACTS ABOUT TEETH AND THEIR CARE. Available from the National Dental Hygiene Association, Washington, D.C., 1942. 16 pp. Free. Approved by The American Association of Public Health Dentists.

TUBERCULOSIS

A STUDY OF PATIENTS DISCHARGED ALIVE FROM TUBERCULOSIS SANATORIA IN 1933. Jessamine S. Whitney and Mary V. Dempsey. Social Research Series No. 8. National Tuberculosis Association, 1790 Broadway, New York, 1942. 58 pp.

HOW TO KILL TB GERMS. Prepared by the National Tuberculosis Association. Available from state and local tuberculosis associations, 1943. 4 pp. Free.

THE COST OF TUBERCULOSIS CONTROL IN THE

DEPARTMENT OF HEALTH, NEW YORK CITY, 1940. H. R. Edwards, M.D. Reprinted from *The Milbank Memorial Fund Quarterly*, January 1943. Milbank Memorial Fund, 40 Wall Street, New York. 16 pp.

THE SHELTERED WORKSHOP IN THE REHABILITATION OF THE TUBERCULOUS: MEDICAL EXPERIENCE AT ALTRO, 1915-1939. Louis E. Siltzbach, M.D. Reprinted from *The Milbank Memorial Fund Quarterly*, January 1943. Milbank Memorial Fund, 40 Wall Street, New York. 22 pp.

PUBLICITY

BULLETINS—HOW TO MAKE THEM MORE EFFECTIVE. Catherine Emig. Available from the Social Work Publicity Council, 130 East 22 Street, New York, 1942. 24 pp. 50c.

A delightful exposition on bulletin-making and recommended reading for all who may need help on such matters as "tone," how to use the materials at hand, appearance, alternative production methods and costs.

"HEALTH EXHIBITS FOR FAIRS AND EXPOSITIONS." Thomas G. Hull. *Hygeia*, 535 North Dearborn Street, Chicago, February 1943, p. 96. Single copy 25c.

Description of American Medical Association exhibits available on a loan basis.

NUTRITION

FOOD AFTER FIFTY. Prepared by Nutrition Committee of Welfare Council of New York City. Available from the Council, 44 East 23 Street, New York, 1942. 4 pp. 5c per 3 copies.

HOW MUCH DO YOU KNOW ABOUT ALCOHOL? Thomas R. Carskadon. Association Press, New York, 1942. 31 pp. 5c; \$3 per 100 copies.

NOTES from the NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

IN THE FIELD

UNIVERSITY OF MONTREAL, Canada, March 31-April 10—Mary C. Connor revisited the University to review the program of study in public health nursing at the request of the Metropolitan Life Insurance Company. While in Montreal, Miss Connor spent four days with the following agencies: L'Assistance Maternelle, the Municipal Health Department, and the St. Jean County Health Department. These agencies take university students for field experience. . . . Ohio, South Dakota, and Kansas, April 3-30—Jessie L. Stevenson conducted orthopedic institutes and conferred with public health nurses, students, and supervisors in these states. . . . KAHLER HOSPITALS, Rochester, Minnesota, April 12—Mrs. Bethel McGrath spoke at the monthly district meeting of the State Nurses' Association. . . . STATE DEPARTMENT OF HEALTH, Syracuse, New York, April 12—Miss Connor visited this agency in relation to her accreditation visit to Skidmore College Department of Nursing last month. This was the last to be visited of the agencies offering affiliation for field experience to Skidmore College students of public health nursing. . . . NEW JERSEY STATE ORGANIZATION FOR PUBLIC HEALTH NURSING, April 16—Mrs. Edith Wensley attended the annual lay section meeting, and the joint meeting of the New Jersey State Nurses' Association, the State League of Nursing Education, and the S.O.P.H.N. held at the Essex House in Newark. S.O.P.H.N. officers elected at its annual business meeting were: Caroline di Donato, president; Grace Anderson, first

vice-president; Emily K. Lydon, corresponding secretary. . . . MASSACHUSETTS ORGANIZATION FOR PUBLIC HEALTH NURSING, Boston, April 27—Hortense Hilbert participated in the discussion of wartime aspects of public health nursing at the special conference held at the Hotel Bradford, the second conference of its kind in Boston.

STATISTICAL GUIDE TO BE REVISED

Revision of "Suggestions for Statistical Reporting and Cost Computation" recommended by the Records Committee, of which Marie L. Johnson is chairman, will be undertaken soon by Margaret Shetland, formerly educational director of the Syracuse Visiting Nurse Association. Miss Shetland, who joined the N.O.P.H.N. staff on May 3 for two months, has an M.A. degree from Teachers College, and is at present completing a study with the Community Service Society of New York. Usefulness to official agencies as well as the nonofficial group will be particularly stressed in the rewriting of the guide.

SALARY SCALES IN VNA'S

Many public health nursing agencies are puzzling about the Government "freeze" order on salaries. A recent letter to the N.O.P.H.N. from the Visiting Nurse Association of Brooklyn (New York) quotes information on this question which will be extremely helpful to many:

Our Board recently filed application with the National War Labor Board for a 10 percent salary bonus for the duration of the war. In reply the local office has informed us that several

N.O.P.H.N. NOTES



Thirty-nine nurses from Whiting, Gary and Hammond attended the meeting of industrial nurses of the Northwest Section of the Indiana State Nurses' Association in Hammond on March 16. The N.O.P.H.N. was represented by Mrs. Bethel McGrath. Pauline Kuehler, center seated, is chairman

visiting nurse associations have made application for "bonuses" which seem to him to be a request for salary increases. He has suggested that if there is a central headquarters where visiting nurse associations go for advice they should be advised to request salary increases and not bonuses as the War Labor Board is opposed to a bonus in the usual sense of that term and might easily turn aside an application without investigation. I am passing this word on to you, feeling it may be of help in advising others. Our Association has received permission to increase our salary scale for the duration.

INDUSTRIAL HYGIENE INSTITUTE

The report of Mrs. Bethel McGrath, N.O.P.H.N. industrial nursing consultant, of the ten day industrial hygiene institute at the National Institute of Health, March 1-10, proves that meetings of nurses are eminently profitable—and fun:

The National Institute of Health covers 110 acres of rolling wooded area in Maryland just outside of Washington. The beautiful surroundings and marvellously clear fresh air were a treat to most of us. An exceptionally good course of lectures were arranged and discussion was stimulating. Most valuable was the opportunity for conferences between sessions with nurses from all parts of the country. Those attending included most of the nursing consultants from state departments of industrial hygiene, regional consultants of the Division of

Industrial Hygiene of the U. S. Public Health Service, representatives from many universities and the national nursing organizations, and supervisors of official and voluntary agencies from many of the larger cities—over 70 in all. On Sunday the Central Committee were invited to Top Cottage where, after a business session before a log fire in the huge fireplace, luncheon was served by Miss Whitlock, Miss Kahl, Miss Heisler, Miss Trasko and Mr. Bloomfield. On the same afternoon everyone attending the institute was invited to Ruth Kahl's home for tea. It was a delicious and happy affair. Everyone took off their hats and stayed through several cups of tea and lots of conversation. Two of our number missing from the party were found upstairs trying on all the hats! The tea gave everyone an opportunity to talk with Miss McIver. Olive Whitlock worked so hard through the whole ten days I don't know how she managed to come out alive! Several excellent papers are promised for future publication in PUBLIC HEALTH NURSING magazine.

NURSING CARE OF THE SICK

"An intelligent and sympathetic analysis of resources and needs" says Dr. Donald B. Armstrong, 3rd vice-president, Metropolitan Life Insurance Company of the N.O.P.H.N. survey "Public Health Nursing Care of the Sick." The study has gone to the printer and will be available about June 1 at 50 cents a copy.

PUBLIC HEALTH NURSING

HONOR ROLL

We salute 260 agencies which have already reported that 100 percent of their staffs are enrolled as members of the N.O.P.H.N.

N.O.P.H.N. will welcome as members: part-time nurses, board members, volunteers and every person who wants to help strengthen public health nursing for the home front. But Honor Roll Certificates are awarded only to agencies in which all the regular full-time staff nurses are enrolled in the N.O.P.H.N. One-nurse agencies also are eligible for the Honor Roll Certificate.

Many more groups are entitled to a certificate we are sure, but have failed to send us that post card which says, "We are eligible." If all full-time nurses on your regular staff are 1943 members of the N.O.P.H.N., send in the post card at once!

ALABAMA

- *Gadsden—Metropolitan Life Insurance Nursing Service
- Hayneville—Lowndes County Health Department

ARKANSAS

- Lake Village—Chicot County Health Department

CALIFORNIA

- Los Angeles—John Hancock Mutual Life Insurance Company
- Sacramento—City Health Department
- *San Bernardino—Metropolitan Life Insurance Nursing Service

COLORADO

- *Greeley—Weld County Health Department

CONNECTICUT

- *Wallingford—Community Nursing Service of Wallingford Tuberculosis and Relief Association

ILLINOIS

- *Oak Park—Metropolitan Life Insurance Nursing Service
- Pontiac—Livingston County Tuberculosis Association

*Agencies which have been on the Honor Roll for five years or more.

INDIANA

- *Evansville—Public Health Nursing Association
- *Fort Wayne—Visiting Nurse League
- *Gary—John Hancock Mutual Life Insurance Company
- *Huntington—City Schools
- *New Albany—Metropolitan Life Insurance Nursing Service

IOWA

- Davenport—Public School
- *Davenport—Visiting Nurse Association

KANSAS

- *Kansas City—Visiting Nurse Association

MAINE

- Bangor Anti-Tuberculosis Association

MASSACHUSETTS

- Attleboro—Metropolitan Life Insurance Nursing Service
- *Boston—John Hancock Mutual Life Insurance Company
- North Adams—John Hancock Mutual Life Insurance Company

MICHIGAN

- Monroe—Monroe County Health Department

MINNESOTA

- Anoka—School Nursing Service
- Aurora—Public School Health Department
- Austin—School Nursing Service
- Bemidji—School Nursing Service
- Bainerd—School Nursing Service
- Cannon Falls—Mineral Springs Sanatorium
- Crookston—School Nursing Service
- Crookston—Polk County Nursing Service
- Crosby—School Nursing Service
- Detroit Lakes—School Nursing Service
- *Duluth—Metropolitan Life Insurance Nursing Service
- Duluth—Parochial Schools
- Fairmont—County Nursing Service
- Faribault—School Nursing Service
- Glencoe—McLeod County Public Health Association
- *Grand Rapids—Itasca County Nursing Service
- International Falls—Nursing Service
- Litchfield—Public Schools Health Service
- Little Falls—School Nursing Service
- Mahtomedi—School Nursing Service
- Mankato—Teachers College
- Minneapolis—Industrial Nurse Service—The Dayton Company
- Minneapolis—Employers Mutual Liability Insurance Company
- Minneapolis—Industrial Nurse Service—Federal Land Bank

PUBLIC HEALTH NURSING

Minneapolis—Industrial Nurse Service—Land O'Lakes
 Minneapolis—Industrial Nurse Service—Minneapolis Knitting Works
 Minneapolis—Industrial Nurse Service—Pillsbury Flour Mills
 Minneapolis—Industrial Nurse Service—Powers Mercantile Company
 Montevideo—School Nursing Service
 Moorehead—College Nursing Service
 Mountain Iron—Indian School District No. 21—School Nursing Service
 New Brighton—Twin Cities Ordnance Plant—Hospital Building No. 105
 Park Rapids—Hubbard County Nursing Service
 Pipestone—School Nursing Service
 Ponsford—United States Indian Service
 Preston—Fillmore County Health Department
 Redwood Falls—School Nursing Service
 Robbinsdale—School Nursing Service
 St. Cloud—School Nursing Service
 St. Paul—Theo Hamm Brewing Company
 *St. Paul—Ramsey County Nursing Service
 St. Peter—Nicollet County Nursing Service
 *St. Peter—School Nursing Service
 Thief River Falls—School Nursing Service
 Thief River Falls—Oakland Park Sanatorium
 Wadena—County Nursing Service
 Winona—Infant Welfare Service
 Winona—County Nursing Service
 Winona—School Nursing Service—Teachers College
 Worthington—School Nursing Service

MISSOURI
 St. Louis—John Hancock Mutual Life Insurance Company

MONTANA

Great Falls—City-County Health Unit

NEBRASKA

Bingham—South Sheridan County District Health Unit
 Gering—Demonstration District Health Unit No. 1
 Grand Island—Hall Adams County Health Unit

NEW JERSEY

*Red Bank—Public Health Nursing Association

NORTH CAROLINA

Asheville—City Health Department
 *Charlotte—Metropolitan Life Insurance Nursing Service

NORTH DAKOTA

Mott—Hettinger County Health Department

OHIO

*Lima—Visiting Nurse Association

OKLAHOMA

*Norman—Cleveland County Health Unit
 Pryor—Mayes County Public Health Service
 Shawnee—Department of Public Health

SOUTH CAROLINA

Pickens—Pickens County Health Department
 Saluda—Saluda County Health Department

TENNESSEE

*Nashville—Davidson County Health Department

WISCONSIN

*Oshkosh—Visiting Nurse Association

Coordinated Care

(Continued from page 238)

nursing service. We will save the time of professional workers if we recognize the separate functions of each professional group as well as the need for both to work together closely with many of the patients.

Is there danger that a public health nurse may become less valuable in that capacity when she remains within an institution over several years? Does she lose her finger-tip information about com-

munities as well as the home and family feel? A few organizations have found it valuable to rotate the privilege of a hospital assignment such as Miss Miller's. It is quite possible Miss Miller would say, if asked, that the assignment had been invaluable to her in improving her scientific knowledge as well as her knowledge of nursing and its problems in the whole state. It is a wonderful staff development opportunity!

Let's have more practical plans and more discussion of them—including this one in Iowa.

NEWS

National Nursing Council for War Service

A BILL "to provide for the training of nurses for the armed forces, governmental and civilian hospitals, health agencies, and war industries, through grants to institutions providing such training, and for other purposes" has been introduced in the House of Representatives by Mrs. Chester C. Bolton of Ohio (H R 2326) and in the Senate, by Senator Bailey of North Carolina (S 983). Provisions of the bill include maintenance and stipends for students, uniforms and insignia, and use in military and other governmental hospitals of a portion of the senior students. The plan would be administered by the U. S. Public Health Service through the Office of the Surgeon General. Members of the student reserve would agree to serve wherever needed for the duration of the war and for six months thereafter. Entrance into the armed forces or assignment to governmental or civilian nursing services essential to the war effort would result upon graduation. The aid of *all* nurses is needed in support of this bill in view of the urgent wartime demands on the profession as a whole!

A small committee, appointed by the chairman of the National Nursing Council for War Service for the purpose of giving advice and assistance wherever needed in relation to hearings on this bill, has been preparing factual material for use in the hearings, listing people who would be helpful in testifying to the need for this legislation, and initiating the legislative routine of the American Nurses' Association for enlisting support of the state nurses' associations and other organizations for the bill.

Ada Belle McCleery, formerly admin-

istrator of the Evanston Hospital, Evanston, Illinois, is in Washington, D. C., as special representative of the American Nurses' Association in connection with hearings on the bill.

Secretaries of state nursing councils for war service have been invited to Chicago for a special meeting beginning the morning of June 17 and ending at noon June 18, at the Drake Hotel, for discussion of the supply and distribution program and problems of student recruitment in relation to HR 2326.

A NEW committee of the National Nursing Council for War Service will consider nursing participation in the postwar foreign relief and rehabilitation program. The committee will hold its first meeting on May 12 at the offices of the Henry Street Visiting Nurse Service, New York City. Elizabeth Tennant of the Rockefeller Foundation is chairman. Other members of the committee are: Hortense Hilbert, Mary Beard, Lt. Col. Florence A. Blanchfield, Naomi Deutsch, Hazel Goff, Mary M. Roberts, Isabel Stewart, Maj. Julia C. Stimson, and Effie J. Taylor.

A separate committee will be formed to deal with such domestic nursing problems as placement of nurses released from wartime positions, job adjustments and vocational preparation for such nurses, and the nursing aspects of the broadened community health programs expected in postwar America.

IN JUNE Edith H. Smith, who has been visiting colleges during the past several months as a special recruitment

NEWS NOTES

consultant of the National Nursing Council for War Service, goes to the Syracuse University School of Nursing as dean. Miss Smith was formerly professor of nursing and director of nursing service at Stanford University Hospital.

MRS. ESTELLE MASSEY RIDDLE, consultant on Negro nursing of the

N.N.C.W.S., has been travelling through the South, visiting Negro colleges and appearing as guest speaker at a number of meetings. The principal purposes of her trip are to interest college women in entering the nursing profession and to help solve some of the problems of providing adequate educational facilities for Negro student nurses.

From Far and Near

• New director of the Bureau of Public Health Nursing in Montclair, New Jersey, is Anna C. Gring—a piece of news which will delight her friends in all parts of the country. Miss Gring was assistant director of the N.O.P.H.N. in 1939-1941, serving as secretary of the School Nursing Section and as editor of the Book Notes section in the magazine. Since January 1942 Miss Gring has been assistant to the director of the Red Cross Home Nursing Service, as educational assistant in home nursing.

• The Merit System Council of West Virginia announces unassembled examinations for the following positions in the State Health Department, with the annual salary ranges indicated:

Consultant Nurse in Special Fields—\$2,400 to \$3,000

Public Health Nursing Supervisor (State Level)—\$1,920 to \$2,400

Public Health Nursing Supervisor (Local Level)—\$1,800 to \$2,160

Applications will be accepted continuously, but new registers will be established from applicants who file no later than June 26, 1943. Residence in West Virginia has been waived. For application blanks and further information,

write to Robert F. Bingaman, supervisor, Merit System Council, 212 Atlas Building, Charleston.

• Eye Health & Safety News, a newsletter on conservation published by the National Society for the Prevention of Blindness, Inc., made its debut in March 1943 with Volume 1, No. 1. Designed to further the Society's services to the field through a pooled reporting of developments and new projects, the four-page bulletin will appear four or five times a year and is free of charge upon request. Suggestions for items of interest to its readers are sought. Write to the Society, 1790 Broadway, New York, N. Y.

Maternity Care for Service Men's Wives—

An item of \$1,200,000 has been appropriated by Congress to meet estimated needs to July 1 for emergency medical, nursing, and hospital maternity and infant care for wives of men in the military services. Care is available to the wife or infant of any "buck" private, private first-class, corporal, or sergeant in the Army and comparable grades of the Navy or Coast Guard. Wives of men in higher ranks are not eligible. The money is part of funds administered by the Children's Bureau under the Social Security Act for maternal and child health, which agency makes grants-in-aid to the states. The states are thus enabled to continue special wartime

(Continued on page A8)

Visiting Nurse Bag

Adopted by Visiting Nurse Association of Chicago



Made of Genuine Seal Grain Cowhide, Cowhide lined, double-stitched and arranged for black rubber or white washable interchangeable linings the Visiting Nurse Bag combines the utmost in smartness and utility.

The lining is equipped to hold in place six two-ounce saddle bag bottles fitted with ground glass stoppers together with nickel-plated screw caps. Loops for two thermometers, pen and pencil, hand scrub brush, soap box, scissors and pocket for report book are provided.

The bag is twelve inches long, six inches wide and six inches deep. Rings and shoulder straps can be furnished on special order. Prices quoted upon request.

Best attention given to repair of bags and linings.

ERPENBECK & SEGESSMAN : CHICAGO : 417 N. STATE ST.

News

(Continued from page 293)

maternity programs started in 1942, threatened because of exhaustion of funds.

Dr. Martha M. Eliot of the Children's Bureau in *Survey Midmonthly*, April 1943, estimates that at least 5 percent of births in 1943 will be to wives of men in the military service, and describes some of the circumstances of childbirth they face under wartime conditions. The Army and Navy provide medical and hospital care for service men's dependents in peacetime, with Red Cross chapters assisting in meeting other family needs. With the tremendous army of today the demand for maternity care has already exceeded usual resources. The Army can no longer provide peacetime services, especially near the large army posts. Dr. Eliot says that a great many service men's wives are between 16 and 20 years of age, pregnant for the first time. They have followed their husbands to town near posts and are not eligible for various community services as non-residents. In one recent month the Red Cross at 240 army posts reported that 3,262 soldiers requested help in securing maternity care, 39 percent for wives living near the post, 61 percent for care of wives living in another state. In many of the home communities public provision for maternity care or medical care for children is not available or is inadequate. The family allowance under the

Servicemen's Dependents Allowance Act of 1942 of \$50 per month for a married woman expecting her first baby or \$60 a month for a woman with one child is not enough to pay some \$70 for maternity care, and more for medical attention for a baby.

The funds now appropriated by Congress ensure development of a well-considered plan to provide this care on a nationwide basis. Experience in the early months indicates that care will be needed for 25,000 women and infants during 1943.

The Children's Bureau has recommended that in communities where official health agencies administer nursing service this include postpartum bedside nursing care to women delivered at home or discharged from the hospital early after delivery. Where possible nursing service is to be made available at home deliveries. When maternity nursing is not available from official public health nursing services the Children's Bureau will consider the use of maternal and child health funds for purchase of this service from nonofficial nursing agencies (*PUBLIC HEALTH NURSING*, January 1943, p. 59).

War-time Vacations—The statement on April 12 by Donald M. Nelson, chairman of War Production Board, applies to public health nurses as to all essential wartime workers:

"I believe that the granting of vacations to industrial workers this year will be helpful to war

PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

Records and Studies

THE WILLINGNESS to review your own work critically is as important as the actual result of your analysis. This willingness carries through to using the results of a study without which use it can have only academic value. While this idea is not new it is appropriate to restate it after reading the three articles on cost analysis and record-keeping which appear in this issue. Although different in character and scope these articles illustrate willingness to review procedures "at home," to find out more about local service, and to find ways for improvement.

To visiting nurse services a cost per visit study is a routine procedure. But in official agencies the study of such costs has been a difficult and complicated problem because of the relationship of the nursing services to other health department activities. The District of Columbia Health Department is to be congratulated for their willingness to undertake what others have hesitated to try.

Mr. Gavens has illustrated well the application of cost study principles to official public health nursing services. To make cost per visit studies conform to budget regulations of the other bureaus of the official agency necessitates some adjustment in method. This is not an easy task. Further experimental study may give us a more accurate method of allocating student nurse program costs. And in the not too distant future, public opinion may no longer tolerate refusal on the part

of administrators to have their costs allocated to specific services. Costs studies are in vogue.

The people of many communities are learning for the first time about their official services through volunteer work in a variety of wartime community projects, and through receiving the benefits of these services in their own homes. Times are changing rapidly and people are beginning to know enough to question the cost of public services and the quality of service for which they pay.

The analysis of rural nursing services by Dr. Scherer illustrates the importance of reviewing not only the amount of nursing service given by an agency but the way in which the service is distributed. This is particularly essential in rural areas when distances are considerable and families living in relatively isolated areas may not receive an amount of nursing service equal to that given to more accessible families in the village.

A measure of quality of service is indicated by the period during which a nurse's visit is made. For example, visits to infants 3 months of age or less are of greater value than visits to infants 11 months of age. One maternity visit within 48 hours after home delivery is more valuable than several maternity visits a week after the baby is born. Such period analyses should be used more often in all public health nursing services. They would assist in selecting services accord-

(Continued on page 305)

Public Health Nursing in Relation to Shortage of Medical Care*

MANY COMMUNITIES, particularly those with greatly increased populations due to war industry or military activities, are now facing a grave shortage of medical personnel—a situation which demands the most economical and wisest use of physicians and nurses.

State Health Officer A. J. Chesley of Minnesota recently said:

Home care of the sick has grown in importance in Minnesota because more than one third of Minnesota's physicians are already in the armed forces, the rural areas having reached the minimum number of physicians essential to safety. . . . It is, therefore, necessary to maintain public health nursing services under the direction of remaining physicians to aid them in the care of the sick. . . .

To meet the medical care crisis planned efforts must be instituted to assist physicians to conserve their time and strength for the most necessary services and for services which only they can give. Where they are available, public health nurses can supplement the services of physicians at certain times in certain ways in order to make the most of local health resources remaining for the civilian population. This entails flexibility in public health nursing policies and practices.

Wartime policies adopted by public health nursing agencies are, of course, based upon the fundamental principle that nurses do not and cannot practice medicine.

To help keep public health nurses and

nursing agencies currently informed about modifications in policies and procedures which, because of shortage of physicians, have already been put into practice or are under consideration, the N.O.P.H.N. has assembled whatever information and opinion is now available from member agencies, state organizations for public health nursing, and state directors of public health nursing. These are summarized as follows:

1. *Changes in hours of work*

Some agencies are making nursing service available for 24-hour periods by staggering the hours of the nursing personnel. In this way nursing service can be provided for the industrial worker whose hours are long and irregular. Many mothers who want the help of the public health nurse are now working away from home during the hours the nurse usually visited the home. In some agencies a longer working day or week has been adopted. Other agencies report consistent overtime by their nurses. It is commendable that some agencies have made provision to give compensation for this additional service.

2. *Screening of patients for medical attention*

In some communities nurses are, at the doctor's request, making first visits to determine the extent of the illness, taking the temperature, and reporting the condition of the patient to the doctor. Thus he is saved time and unnecessary travel. Doctors who have had this cooperation from nurses are enthusiastic about the

* Compiled in the office of N.O.P.H.N. from information received from the field.

MEDICAL CARE SHORTAGE

help they receive. In some of the California federal housing developments where the California Physicians' Service, Inc., provides medical care and where graduate nurses (not necessarily public health nurses) are employed directly by the corporation, it has been discovered that two nurses double the capacity of one physician. Here, the nurses assist in the dispensary, make home visits, and respond to emergency calls. It has been found that in a surprisingly high percent of emergency home calls either the emergency is slight and over and the nurse can give whatever care is needed, or is serious and the nurse can arrange immediately for transportation to a hospital.

In some nursing agencies standing orders have been expanded to provide for nursing advice and care before the physician is called, especially in case of sick children and chronic illness. Where such advice is given, the nurse reports her visit to the physician. Through such a plan continuous supervision is provided the patient; direct contact is maintained between the patient and physician; and medical attention is insured as needed.

3. *Nursing service at home deliveries*

It is now becoming the usual practice among public health nursing agencies to have the nurse remain with the patient during labor, observing the patient's progress, keeping the physician informed of her condition, and calling him when delivery seems imminent. Formerly, it was customary in the majority of agencies administering a delivery service for the public health nurse to arrive and to leave with the physician. Also, most agencies are now revising their policies in regard to post-delivery service by the nurse after the doctor leaves.

Now that physicians are busier than ever, the chances of their not arriving in time to deliver the baby are also greater. In some agencies it is believed that medical directions in written form should be

provided public health nurses to cover such exigencies, in addition to systematic preparation in advance of obstetrical emergencies.

4. *Clinics and health conferences*

In some communities where every session of the child health conference was formerly attended by a physician, a considerable portion have now become nursing conferences. The physician continues to supervise the conferences and provisions are made for the nurse to reach him by telephone when necessary. Or, instead of attending each weekly session, the physician may come once in three or four weeks, while the public health nurse comes every week.

Medically approved standing orders covering formula adjustments for well children, additions to normal diet, and general child care are being obtained by nursing agencies whose nurses serve in well-child health conferences.

Individual orders for procedures to be carried out by nurses in child health conferences, such as immunization against diphtheria, smallpox and the patch test for tuberculosis, should also be secured from physicians in written form when these activities are to be carried out.

In some venereal disease clinics, nurses are expected to administer intravenous and intramuscular injections in the treatment of syphilis. This type of technical service may be given, provided the nurse has been sufficiently well instructed, and provided the physician is present at the clinic or has given a written order for the particular treatment to a particular patient.

5. *The use of non-nurse helpers*

If the public health nurse accepts added responsibility to help ease the medical shortage, she must also conserve her own time through the use of non-nurse helpers. Many agencies reported the satisfactory use of the non-nurse helper in performing many services formerly given by public

PUBLIC HEALTH NURSING

health nurses, both in home and office.

GENERAL SUGGESTIONS

General Planning in Regard to Extension of Public Health Nursing to Help Relieve Medical Shortage

1. Public health nursing should be represented in all general planning for medical care which involves nursing so that new and increased nursing activities can be considered from the point of view of sound nursing administration and procedure. State organizations for public health nursing or units of public health nursing in state departments of health can be consulted for suggestions as to the public health nurse member of the general planning committee.

2. General plans for the nursing aspects of medical care should include consideration of how diagnoses and medical orders can best be provided public health agencies in communities where physician shortage is acute. The state medical societies and state departments of health should be asked to assume responsibility in this connection.

Local Provisions for Extensions of Public Health Nursing Service

1. Locally, when nursing services are needed by patients who are not able to get a doctor, diagnoses and medical orders should be available to the public health nurse from the city or county physician or medical health officer.

2. Part-time nursing service can be most economically and efficiently obtained from a community nursing service such as a visiting nurse association or a nursing unit of a health department, which provides for competent nursing direction and supervision, and which makes service

available to those who can as well as those who cannot pay for it.

3. Local agencies, together with their medical advisory boards or committees, should review past policies in the light of possible revisions in program, which will enable them to give as much assistance as possible to overworked physicians.

Apropos of this last suggestion, one director of a visiting nurse association has written her medical advisory committee: "I have a feeling that the doctors are not using our staff of more than 40 graduate nurses to save time for themselves, at least not to the extent that they might. For example, the nurses speak of doctors making calls at 10:30 and 11 o'clock at night to check a temperature, do a dressing, or to see whether or not symptoms have abated as the result of medication ordered on the previous day. Perhaps the nurses might to a greater extent act as the doctor's eyes and ears, as well as his hands and feet, and save him these late calls and the resulting physical exhaustion. There are certainly many instances where a visit from a nurse and an immediate report by telephone might save the doctor that late visit after a hard day's work."

In making the fullest and best possible use of public health nursing to supplement medical care in communities of physician shortage, the limitations of endurance of the public health nurse must naturally also be borne in mind. For instance, a public health nurse working alone in a community can hardly be expected to be on call 24 hours a day, day after day. In order to add many of the services of the kind here mentioned, some additional public health nursing personnel will be required in some communities.

Public Health Nursing Costs in a Health Department

By HENRY GAVENS.*

FACTS CONCERNING the cost of a public health nursing service may be desired for many reasons, but the most usual of these are:

1. To assist in making budgetary estimates.
2. To make comparisons with recognized standards or with other similar nursing organizations for the purpose of measuring the relative efficiency of operation.
3. To serve as a basis for making charges for services rendered to insurance companies, industrial companies, private individuals, or to other cities (as by a county organization).

It is important to establish the purpose for which the costs are to be used because the purpose determines the method which will be followed.

Costs which are to be used for the purpose of making budget estimates should be compiled according to the classifications in which the local budget is set up. These classes vary from one community to the next. No particular difficulty is usually encountered in making such compilations and so it will not be necessary to discuss that subject here.

The use of costs for checking efficiency is so difficult that such use cannot be recommended at this time. A series of

operating ratios usually can measure efficiency of operation more effectively than can a series of unit costs.

The discussion which follows will be confined to the problems which arise when costs in a generalized service are desired for the purpose of setting prices. An analysis to determine costs for this purpose was undertaken in the Health Department of the District of Columbia based on operations in the fiscal year 1941. It was decided to observe three principles in carrying out that analysis: (1) clinic and home costs should be separated (2) the cost of clinic work should be allocated to the respective clinic service in which it was performed (3) the cost of each class of home visit should likewise be allocated to that bureau in the department for which the visit was made.

The following questions arose during the course of the study and will be discussed in turn:

A. What data on performance and on costs are necessary?

B. How shall depreciation be charged?

C. What "hidden" costs are involved?

D. What shall be done about the student nurse program?

E. How shall the cost of the bureau of administration be allocated to the nursing bureau?

F. How shall the clinic and home costs of the nursing bureau be allocated to the line bureaus?

*A report prepared for the N.O.P.H.N. Subcommittee on Costs in Official Agencies: Josephine Pitman Prescott, chairman; Thomas W. Scott, Henry Gavens, Dorothy E. Wiesner, Marian Randall, Mildred Sanderson, Margaret G. Wohlgenuth, Emilie G. Sargent, Dr. Ira V. Hiscock, Marie Johnson, Hazel V. Dudley, Cecilia E. Walsh.

A. DATA ON PERFORMANCE AND ON COSTS

In order to find the unit cost of any type of service it is necessary to have data on performance and on costs. The former are divided into the latter to obtain the unit cost.

With respect to performance it was necessary for this study to have the number of home visits tabulated according to the line bureaus for which the visits were made. In the District of Columbia during the fiscal year 1941 the following number of home visits were made by nurses: maternity 15,448; school 2,885; infant and preschool 11,745; communicable disease 188; tuberculosis 5,951; venereal disease 4,287; handicapped children 1,719; unclassified 1,469; total 43,692. Unproductive (not at home) visits which occur in any service and amounted to 7,801 were included in these figures.

Work performed by nurses in clinics such as office interviewing has not been recorded in the performance data for purposes of this particular study. The corresponding cost of nursing time and supplies consumed in clinics have been charged directly to the line services concerned.

The data on costs were grouped under the classifications shown in Table I as follows:

Administration, Health Department. The

bureau of administration in the Health Department is a staff function which renders assistance to all bureaus in such matters as policy formulation and guidance and such routine duties as purchasing, stores, personnel, finance, mails, messengers and telephone service. The methods which have been considered for allocating the cost of operating this bureau to the line bureaus will be described later.

Administration, Nursing Bureau. The charges included here were the salaries of the director of the Nursing Bureau, secretary to the director, assistant director, consultant on statistics and records, and secretary to the consultant.

Supervision. The salaries paid to nursing supervisors and consultants were shown in this classification.

Nurses' Salaries. This classification shows the total amount paid to nurses during the fiscal year.

Clerical Salaries. The total amount paid to clerks employed in the nursing offices is shown here.

Transportation. This account shows the amount expended from public funds for street car and automobile transportation of employees in the Nursing Bureau. Sums expended by employees from their own personal funds have been excluded, even though such sums may have been used in connection with their official duties.

Supplies. The total amount expended for scientific and office supplies by employees of the bureau in connection with the performance of duties related to field visits is shown here. Materials used by nurses in clinics are charged to the clinics and are not included in this item.

Printing and Binding. The amount expended for printing material such as forms used by

TABLE I
DIVISION OF TOTAL COSTS BETWEEN CLINIC WORK AND HOME VISITS

Expense	Total	Home	Clinic
Total	\$212,769	\$53,551	\$159,218
Administration, Health Department	12,666	2,239	10,427
Administration, Nursing Bureau	12,730	2,251	10,479
Supervision	22,145	3,915	18,230
Nurses' salaries	145,872	25,790	120,082
Clerical salaries	12,773	12,773	0
Transportation	880	880	0
Supplies	1,114	1,114	0
Printing and binding	127	127	0
Communication	928	928	0
Rent	2,580	2,580	0
Depreciation (\$14,308 ÷ 15 years)	954	954	0
Electricity, gas, water (if separately billed)	—	—	—
Other	—	—	—

nurses in field work is included in this account.

Communication. This account shows the amount expended by the nursing offices for postage, telephone service, and telegraph service.

Rent. This classification includes the total amount chargeable in rents to the Nursing Bureau—\$215 a month or \$2,580 for the year. This Bureau occupies space in schools, maternal and child welfare centers, police stations, and the executive offices of the Health Department. It actually pays no rent on any of these quarters. It was necessary, therefore, to estimate what the charges would have been if the quarters had been rented. The cost of heat, electricity, and janitorial service was included in the rental estimates unless separately provided.

Depreciation. This account shows the amount charged to the nursing bureau for depreciation on its equipment. The problems encountered in making such charges will be discussed later.

Electricity, Gas, Water. If charges for utility services are made separately from rent they may be shown in this classification.

Other Expenses. This classification has been set up to catch all related expenditures not provided for in one of the other groups.

B. DEPRECIATION

The total value of equipment owned by the Nursing Bureau in its several offices amounted to \$14,308. It was believed that the life of this equipment on the average would be approximately 15 years. All of the equipment had been purchased within the last six or seven years and it was in good condition. Detailed depreciation schedules were not set up item by item because of the large volume of work involved. The depreciation charge for the year was computed by simply dividing the total value of the equipment by the arbitrarily selected number of 15 years.

An alternative method would have been to charge equipment items to the cost of operation in each year as they were purchased. This method would have been satisfactory in the case of organizations which were fairly stable, and in which such purchases represented mostly replacements. In the District of Columbia, however, the Nursing Bureau was still expanding with the result that equipment purchases tended to be very heavy in some years and low in others. Even this fact,

however, would not cause a very appreciable fluctuation in unit cost from year to year because the amount spent for equipment is small when considered relative to the total amount expended in the operation of the Bureau.

C. HIDDEN COSTS

The term "hidden" costs is applied to those costs which do not appear in a nursing bureau's budget. They consist of such items as gas, electricity, water, heat, rent, and any other expenditures which may be made by an entirely different department on behalf of the nursing bureau. The amount of these expenditures should be estimated and added to nursing costs because they represent real costs to the government which supports the activities. Donations by private organizations which do not represent charges to the government, however, are excluded. Services obtained from such organizations as the Work Projects Administration are also excluded, but expenditures from Children's Bureau or United States Public Health Service subsidies are included.

D. STUDENT NURSE PROGRAM

In order to make allowance in the costs for a student nurse program, a time study should be made to show the amount of time given by the supervisors and regular nurses to the education of students. The amount of supplies, and other items consumed by the students or in connection with the student program should also be charged separately to that program. The value of the number of visits made by students should then be obtained and compared relative to the cost of the program to see whether a gain or loss had been sustained.

Such a careful analysis, however, is probably not warranted unless the student nurse program is relatively large. In the District of Columbia separate time and cost records were not kept. The cost of training student nurses was merged with the total cost of operating the Bureau and the number of visits made by the

PUBLIC HEALTH NURSING

students was similarly included in the number of visits made by regular members of the staff. The unit cost of a nursing visit as shown in Table III, therefore, took into consideration both the cost of the student nurse program and the number of visits made by the nurses.

In the District of Columbia, 16 student nurses were assigned to the Health Department for a period of two months. The first month was devoted to training them, while for part of the second month they were permitted to make some home visits independently. These 16 nurses made a total of 839 visits. The number of visits which a regular nurse would make per annum, allowing one hour per visit, would be 1,729. It was decided, therefore, that the assistance rendered by all the student nurses combined during the short period of time that they were with the department was the equivalent of one-half of the services of a regular nurse for a full year. This proportion was added to the total number of regular nurses available for the fiscal year 1941, in order to permit a computation of the total cost of carrying a nurse (Table III).

E. ALLOCATION OF COST OF HEALTH DEPARTMENT ADMINISTRATION TO NURSING

The total cost of operating the Bureau of Administration in the fiscal year 1941—\$50,869.52—could have been allocated to the line bureaus on four bases:

1. According to the percentages which each line bureau's expenditures were of the department's total expenditures.
2. According to the percentage which each line bureau's budgets were of the department's entire budget.
3. According to the percentages which each line bureau's personnel was of total personnel.
4. According to the percentage of time devoted by employees in administration to rendering service for each of the line bureaus.

When the cost of administration was allocated to nursing on the basis of expenditures, the proportion was 24.9 percent,

or \$12,666.51. On the basis of relative budgets it was 20.4 percent, or \$10,377.38. On the basis of personnel it was 24.8 percent or \$12,615.64, and on the basis of a time study it was 10.9 percent or \$5,544.78.

Two forms of the time study method of allocating administration expense may be used. In one the clerks are merely asked to estimate how much time they give on the average to the nursing bureau while in the other they keep an actual running record of how they spend their time over a period of perhaps two weeks. The latter form seems on the surface to be more reliable, but it involves considerable effort on the part of the staff in keeping the detailed records. Still another difficulty lies in the fact that it often is practically impossible to obtain full cooperation from the top executives whose salaries have the most influence on the distribution. In view of these facts it was decided for purposes of this particular analysis to have the members of the Bureau of Administration merely estimate how they apportioned their working time. The result thus obtained, 10.9 percent to nursing, seemed low. The percentage based on expenditures, 24.9 percent, was used instead.

Caution must be exercised in allocating costs of administration by any method other than a time study in order to make certain that the allocation is in proportion to the amount of service rendered to the bureaus which are to bear the cost burden. For example, in some departments the bureau of administration may keep central files or provide telephone or messenger service for some of the bureaus, but not for others.

F. ALLOCATION OF COST OF NURSING BUREAU TO LINE BUREAUS

After all the costs of operating the nursing bureau have been assembled, the final problem is how to distribute those costs among the line bureaus. This distribution involves three steps: (1) division of total costs between clinic work and home visits (2) division of clinic costs

NURSING COSTS IN A HEALTH DEPARTMENT

TABLE II
DISTRIBUTION OF THE COST OF CLINIC WORK AND HOME VISITS AMONG LINE BUREAUS

Line bureaus	Total	Home	Clinic
Total, all bureaus	\$212,769	\$53,551	\$159,218
Maternity	45,734	16,119	29,615
Child health			
School	31,863	8,140	23,723
Infant and preschool	72,172	17,083	55,089
Handicapped children	3,357	1,446	1,911
Acute communicable disease	1	1	1
Tuberculosis	23,070	4,123	18,947
Venereal disease	35,718	5,944	29,774
Unclassified service	855	696	159

¹ 188 field visits were made in 1941 to cases of communicable disease, but none of these visits was made during the period of the time study. No costs were, therefore, allocated to that function.

among the line bureaus and (3) division of the cost of home visits among the line bureaus.

1. *Division of total costs between clinic work and home visits.* In the District of Columbia a continuous record was kept throughout the year of the amount of nurses' time devoted to work chargeable to clinics and the amount chargeable to homes. It was unnecessary, therefore, to make a special time study to obtain a breakdown as between these two main groups. A summary of the records showed that 17.68 percent of the nurses' time was devoted to work related to homes while 82.32 percent was devoted to clinics. Costs such as administration, supervision, and nurses' salaries which clearly could not be charged to home visits were divided as between homes and clinics according to these percentages (See Table I).

2. *Division of clinic costs among line bureaus* (82.32 percent of total). The amount of time which nurses spent at work in clinics of the different line bureaus was also kept on a continuous basis throughout the year. Here again it was not necessary to make a special time study to obtain a basis for distributing costs. An analysis of the records showed that the 82.32 percent of all nurses' time which was devoted to work in clinics was distributed among the line bureaus in the following proportions: maternity 18.6 percent, school 14.9 percent, infant and

preschool 34.6 percent, tuberculosis 11.9 percent, venereal disease 18.7 percent, handicapped children 1.2 percent, and unclassified 0.1 percent; total 100.0 percent. The foregoing percentages were applied in Table II, column 4, to divide the amount of \$159,218 expended for clinics among the different line bureaus.

3. *Division of the cost of home visits among the line bureaus* (17.68 percent of total). The 17.68 percent of nurses' time devoted to work in homes can be distributed among the line bureaus on two bases: (a) number of visits made on behalf of the different line services and (b) the amount of time, as determined by a time study, spent in connection with visits made on behalf of the line services.

The number of visits made to different types of cases was regularly tabulated and easily obtainable. If costs could have been prorated in proportion to the number of visits made, it would have been unnecessary to make a detailed time study. A cost allocation made on that basis, however, would have had an important weakness in that the unit cost of a home visit would have turned out to be the same in each of the different line bureaus. It then would not have been possible to make comparisons between bureaus or to make separate charges to organizations purchasing nursing service in proportion to the unit cost of various types of service rendered. Under such circumstances there

PUBLIC HEALTH NURSING

would have been no point in computing a separate unit cost for the different types of services.

The procedure for making a time study will not be discussed here. A description of such a study is contained in Marion Ferguson's "What Do We Do with Our Nursing Time?"* By means of such a study it was found that nurses distributed their time in the field according to the following percentages: maternity 30.1 percent; school 15.2 percent; infant and preschool 31.9 percent; tuberculosis 7.7 percent; venereal disease 11.1 percent; handicapped children 2.7 percent; unclassified 1.3 percent; total 100.0 percent. The total cost of work in homes (\$53,551) was distributed among the line bureaus according to these percentages (Table II, Column 3).

Care should be exercised in planning a time study to make certain that the period of time selected is representative, otherwise the results may be biased. Usually

it is desirable to select a two-week period in each of the four seasons of the year. The amount of work involved in making such an analysis every year or two, however, may be rather burdensome on the average nursing organization. Much the same result can be obtained by determining the average number of minutes spent on a visit for each line bureau and then multiplying that number of minutes by the number of visits made for each line bureau. The result will be a weighted distribution of nurses' time among line bureaus. Percentages similar to those given in the preceding paragraph may be computed from the resulting data to show what proportion the time given to each bureau was of the total. Then the cost of work in homes may be distributed on that basis. The total cost of the service thus obtained for each bureau may next be divided by the number of visits made for that bureau in order to obtain the unit cost of a visit.

The average amount of time spent in making each different kind of visit may

*PUBLIC HEALTH NURSING, March 1941, p. 144.

TABLE III
COSTS PER NURSE, COSTS PER FIELD VISIT, AND COSTS PER CASE

Line bureaus	Cost per nurse		Cost per nurse's field visit		Cost per case	
	Number of nurses	Cost per nurse	Number of field visits	Cost per visit	Number of cases ¹	Cost per case
Total, all bureaus	80.9 ²	\$2,630	43,692 ³	\$1.23	40,404	\$5.27
Maternity	16.8	2,717	15,448	1.04	9,726	4.70
Child health						
School	10.9	2,918	2,885	2.82	9,223	3.45
Infant and preschool	26.5	2,719	11,745	1.45	11,865	6.08
Handicapped children	1.3	2,602	1,719	0.84	619	5.42
Acute communicable disease	0.1 ³	—	188 ⁴	—	101	—
Tuberculosis	10.0	2,319	5,951	0.69	2,641	8.74
Venereal disease	13.8	2,598	4,287	1.39	6,052	5.90
Unclassified service	1.5	555	1,469 ⁵	0.47	177	4.83

¹ Consists of new admissions never previously seen, plus old cases readmitted from the previous year. Number of cases exceeds number of visits in some instances because they include cases admitted through the clinics to whom no home visits were made.

² Includes 0.5 of a nurse to allow for students.

³ Includes 7,801 non-productive visits and 839 visits by student nurses.

⁴ None of the 188 visits to cases of communicable diseases was made during the period of the time study. No costs were allocated to that function.

⁵ Include use of nurse for ambulance and miscellaneous purposes.

NURSING COSTS IN A HEALTH DEPARTMENT

be checked by means of a new study every few years as it appears necessary. Such an analysis, however, probably would not need to be made so often as would a time study of the kind previously mentioned.

CONCLUSION

The findings of this cost analysis are presented in Tables II and III. These tables show the cost of providing a nursing service in clinics and in homes divided according to the line bureaus for which the service was rendered. They show not only the total amount spent, but also the expenditure per nurse, per field visit, and per case. If the Nursing Bureau were paid on a unit basis for the work which it performed, Table III indicates the minimum average charges which would have to

be made in order to enable the Bureau to break even, without either a profit or a loss.

The unit costs shown may be used to make comparisons with similar figures in other departments just to see how charges would vary, but they must not be used as measures of efficiency. In other words, the mere fact that unit costs in one department are higher than those in another does not necessarily mean that it is relatively less efficient. It may, in fact, be more efficient. The variation may be due to differences in quality of service rendered, functions performed, type of health problem existing in the community, amount of traveling necessary, level of prices, political factors, and the so-called "hidden" costs described previously.

Records and Studies

(Continued from page 295)

ing to relative values at a time when selection is necessitated by increased demands for nursing service and by shortages of nursing personnel.

Perhaps the most interesting heading used in Dr. Scherer's study is "Wherein the Lack?" Such a question indicates the divine discontent which makes for progress and improvement.

Miss Kay has tackled records in a lighter but none the less meaningful vein. It would be gratifying to use all her records for study and to use one of her family records if you visited the family to give nursing care as Miss Kay's successor.

The essential points usually given to

students in class discussion of records are written in a somewhat breezy language. If it is easier to read and understand these essential points when presented in this style, perhaps supervisors should take note. Or perhaps staff nurses should always lead class discussions and learn from one another.

Records and studies no longer bring forth the same sighs and scowls they used to bring, for they are understood and used. These three articles are examples of the sincere interest being applied in many agencies to improve public health nursing services. That the authors have offered their contributions to PUBLIC HEALTH NURSING for publication means that the results of their efforts can be shared and the magazine made of real "local" value.

MARIAN G. RANDALL, R.N.

Summer Diarrhea*

By EDWARD DAVENS, M.D.

ALTHOUGH in recent years the number of infants dying from diarrhea has been reduced, this malady is still a very important factor in Maryland infant mortality, as it is in many other parts of the country. It is essentially a seasonal disease of the warm, humid summer months, and this is an opportune time to take stock and renew efforts to control its occurrence.

Infant diarrhea or "summer complaint" is probably due to a *combination of several factors working together*. Bacillary dysentery ("blood flux") is a separate entity due to a specific germ which fortunately has shown signs of yielding to some of the newer chemotherapeutic drugs. The present discussion is limited to infant diarrhea, exclusive of bacillary dysentery.

The "several factors" mentioned above which contribute to the production of diarrhea can be conveniently divided into four groups:

- I. Poor general nutritional state
 - A. Irregularity of feeding and incorrect amounts
 - B. Insufficient minerals and vitamins, resulting in
 1. Poor resistance to infection
 2. Nutritional anemia
- II. External heat
 - A. Lowering of digestive capacity
 1. All intestinal juices inhibited
 2. Excessive fermentation of undigested food
- III. Improper hygiene
 - A. Unboiled and unrefrigerated milk with excessive number of bacteria (not specific pathogens) and their toxic products
 - B. Dirty hands and feeding utensils
 - C. Flies

IV. Various infections

A. An infection in some part of the body other than the bowel is often the "trigger mechanism" which starts the diarrhea. Usually it occurs in the form of an upper respiratory infection, *e.g.*, cold, otitis, pharyngitis, etc.

Any combination of two or more of these factors spells *diarrhea*. The amount of food should be reduced, and the water intake increased even *before* the stools become abnormal. Early danger signs are apathy and general bodily inactivity, refusal of food and vomiting. Then comes the increase in number and alteration in character of stools. When the syndrome progresses, the end-picture is a limp, ashen or cyanotic baby with an irregular respiration which may be acidotic in type. The skin is inelastic, the eyes and fontanelle sunken, and the pulse rapid and weak. In brief—*shock*.

Treatment should be directed toward prevention. The general nutritional state of the infant should be maintained by regular visits to a private physician or a child health conference for advice on feeding and good daily routine. Excellent booklets on this subject are obtainable from state and local health departments, from the Children's Bureau, and other agencies.

The effect of external heat can be minimized by not over-dressing the infant, ventilating his room as much as possible, and giving plenty of water.

During the warm months, attention to details of cleanliness, such as boiling milk, washing hands and utensils and screening from flies should be redoubled.

*From *Monthly Bulletin*, Maryland State Department of Health, April 1943.

NURSE PLACEMENT SERVICE

When an infant develops a cold or other infection in the summer, his food intake should be reduced and his water intake increased. He should be kept in bed and given extra care.

When diarrhea does occur, the management is based on these principles: (1) rest of the bowel by stopping all food for a time (2) replacement of lost water and

salt, either by mouth or parenterally (3) gradual resumption of food and (4) treatment of coincidental infection and good nursing care.

It should be remembered that shock and acidosis may develop with lethal rapidity and one should not delay in severe cases to hospitalize the baby in a hospital equipped for such special pediatric emergencies.

NURSE PLACEMENT SERVICE

N. P. S. announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom consent to publish these has been secured in each case from both nurse and employer.

PLACEMENTS

- *Mrs. Sybil Bellos, director, Town Nursing Service, Greenwich, Conn.
- *Catherine L. Austin, supervisor, Visiting Nurse Association, Pawtucket, R.I.
- *Dorothy L. Campbell, supervisor, Peoria Department of Health, Peoria, Ill.
- Mrs. Marguerite L. Hays, supervisor, Tuberculosis Institute of Chicago and Cook County, Chicago, Ill.
- *Esther Ferne Dickison, school nurse, Hammond Public Schools, Hammond, Ind.
- *Mrs. Dorothy C. Burlingham, public health nurse, Charlemont Branch, Massachusetts, American Red Cross, North Atlantic Area, New York, N.Y.
- Mrs. Leona Gaska Brady, industrial nurse, Central Scientific Company, Chicago, Ill.
- Mrs. Mabel Tilley Conover, industrial nurse, Continental Illinois National Bank and Trust Company, Chicago, Ill.

- Mary C. McParland, industrial nurse, Edward Katzinger Company, Chicago, Ill.
- Mrs. Helen B. Schack, industrial nurse, Standard Transportation Corporation, Chicago, Ill.
- *Lyndall Helen Birkbeck, staff nurse, Visiting Nurse Association, Detroit, Mich.
- *Mrs. Jessie Parks Collins, staff nurse, Visiting Nurse Association, Evanston, Ill.
- Marguerite Jane Glenn, clinic nurse of Louis E. Schmidt Clinic of Montgomery Ward Clinic of Northwestern University, Chicago, Ill.

ASSISTED PLACEMENTS

- *Mabel H. Shonley, director, Visiting Nurse and Tuberculosis Association, Atlantic City, N.J.
- *Mrs. Mildred D. Byers, regional nurse deputy, 9th Regional Office of Civilian Defense, San Francisco, Calif.
- *Arlene Risdon Mansfield, public health instructor, The Children's Hospital, Philadelphia, Pa.
- Abbie Whidden, nursing consultant, American Red Cross, Eastern Area, Alexandria, Va.
- Mrs. Alice Campbell Krotcher, public health nurse, Pacific Area, American Red Cross, San Francisco, Calif.
- *Mrs. Marion L. Juergens, field nurse, Community Service Society, New York, N.Y.

*The N.O.P.H.N. files show that this nurse is a 1943 member.

"Casualties of war" is a tragically familiar phrase these days. The words "so many dead," "so many wounded," "so many missing" are fraught with human grief and suffering. Yet possibly there are other tragic casualties of war, less obvious to be sure, less easy to enumerate, perhaps slow in making themselves felt. Those of us who have been concerned with the well-being of children—and what public health nurse has not—know too well how children pay for war. Even though we may say, "Our health record is good in spite of the fact that we are in the midst of war"—and this is actually true, thanks to a never-relaxing public health program—we know that we are faced with situations for children that can inflict deep and lasting injury to personality growth, the consequences of which reach far into the future. Insecurity, hate, fear, violence, and then war again! Can nothing be done to stop it? Yes, plenty—and one thing at this very moment. We as public health nurses can throw all our weight into promoting the best of care for children whose mothers must go to work, whether they work in defense plants or in essential civilian industries. More mothers can work well only if they know their children are well cared for, and the community must give them that care. Responsibility is not limited to any one group of professional people. It belongs equally to lay people, parents, educators, the church, social and public health workers. All have a contribution to make. Where can we better join forces than in a program for the welfare of these children whose homes seem cut out from under them because of the demands of war!

—WINIFRED RAND, R.N.

Public Health Nursing Services in Child Day Care Centers *

THE WAR MANPOWER Commission has stated that there shall be no active recruitment of mothers with young children until all other labor resources are exhausted, or in great emergencies. *Unnecessary* employment of mothers with young children is being discouraged by other groups concerned with the welfare of children as well as government agencies. This is a subject in which a great many factors are involved and it is not the purpose to go into them in the statement which follows. In places where day care centers are demonstrated as a necessity adequate health standards must be established. The part which public health nursing plays in the formation

and observance of these standards is our present concern.

Health services for young children of working mothers must be rated an essential in wartime. When fewer physicians and nurses than usual are available for the civilian population, conservation of personnel through the fullest use and co-ordination of community resources is of utmost importance.

It is not usually possible or necessary for every day care center to have a full-time nurse, but there must be provided nursing and health supervision in the amounts, of the kinds, and at the times that it is needed.

The best source of part-time nursing is the organized community nursing service, such as the visiting nurse or public health nursing association or the nursing division

*Prepared by a subcommittee of the Council on Maternity and Child Health of the National Organization for Public Health Nursing.

DAY CARE CENTERS

of the health department. Agreements can be made between the group responsible for the operation of the day care center and the public health nursing agency to obtain service on an hourly or part-time basis. If the public health nursing agency cannot provide this service, the public health nurse can help find and give guidance to other nursing personnel.

Ways in which public health nurses can and should be expected to participate in the community program of day care for children of working mothers are as follows:

I. Serving on the committees responsible for planning and operating day care centers

Because of close acquaintance with many families and particularly mothers of young children, and through the various types of health service which public health nurses give in homes, health centers, schools, and industrial establishments, they are in a good position to know the needs for child care in their communities or districts.

They can interpret the needs as they know them to the group responsible for planning and operating the day care program for children. Also, they can interpret to the parents the kind of care their children need and can expect from a day care center, and the importance of parent participation and support in creating an environment that is safe, healthy, and conducive to the best emotional and social development of their young children.

Counseling services are sometimes developed in connection with day care centers for mothers who need or feel that they should work outside their homes. Public health nurses can also function through these services in cooperation with other workers.

II. Helping in the selection and equipment of quarters for day care centers

When new centers are to be established the public health nurse can help in the location of suitable quarters. Experience has shown that it is usually a matter of arranging and equipping whatever rooms can be found rather than selecting the best among several locations.

Guiding factors include accessibility, heating, dryness, sunshine, ventilation, screening of windows and doors, water supply, fire and other hazards, stairs, condition of floors, bath and toilet facilities, care of wraps, indoor and outdoor play space and equipment, facilities for rest and isolation, for storage, refrigeration, preparation and serving of food, for care of dishes and other utensils, and for garbage collection.

III. Helping in the formulation of policies governing child health

Definite policies need to be drawn up in regard to:

Age groups to be cared for

Personnel necessary to insure adequate health supervision

Immunization against smallpox and diphtheria (typhoid fever, whooping cough and tetanus are also sometimes included)

Medical examination of children before admission to the center

Medical examination of day care center personnel, including X-ray examination of the chest

Provisions for continuing medical supervision

Prevention and control of communicable diseases

Prevention of infection and other illness

Prevention of accidents in center, playground and street

Care of injuries and emergency illnesses

Medical standing orders for nursing services in case of illness or accident

Notification of family, doctor, or nurse in case of illness or accident

PUBLIC HEALTH NURSING



A Seattle visiting nurse checks each child upon arrival at the University Y.M.C.A. Play Nursery to prevent the possibility of spreading infectious diseases among the children

Return of child from center to home
in case of illness or accident

Readmission of child after absence due
to illness

Illness of staff members, including
colds

Daily regimen of child

Periodic weighing and measuring

IV. Helping in the training of personnel

It will probably not be possible to staff day care centers entirely with professionally trained personnel. Volunteers will also be used. They will be chosen because of their interest and ability in working with children. Before being assigned to day care centers they are given some systematic preparation which should include the physical, emotional and social aspects of child development and care. Professional workers, too, may need supplementary training in the

health aspects of child care. Public health nurses can contribute to this training.

V. Continuous health advisory service to the day care center staff

The public health nurse can help the day care center workers caring for children in the same way that she helps mothers in the children's own homes.

She may consult with them in respect to:

1. How to look for signs of communicable disease
2. Need and method of isolating children with suspicious signs of illness
3. What to look for in the way of deviations from usual health—fatigue, irritability, loss of appetite, and how to bring such deviations to the attention of parents, physicians, and public health nurses.
4. Recognition of emotional conflicts

DAY CARE CENTERS

and unhappiness in the child which may be reflected in physical complaints or behavior

5. Control of the physical environment—fresh air, sun, temperature, in- and outdoor clothing, cleanliness, sleep and rest, meals

6. Provision of enough and the right kind of food

7. Play equipment and toys for fostering good motor development

8. Planning the daily activities of the group

9. Planning the day of the individual child in the light of his particular physical condition (as revealed by medical examination) according to medical recommendations and knowledge of the child's home care

10. Maintenance of good health habits

11. Relating the care of the child in the center to that in his home in respect to food, sleep, rest, and other aspects

12. How to prevent accidents and infection

13. First aid and simple nursing procedures pending medical and nursing care for illness or injury

14. Normal development of the individual child and his behavior.

VI. Helping mothers who work away from home to plan for the care of their children

Once a day care center has been established, mothers need to be thoroughly informed in regard to the care it offers, where its responsibility begins and ends, and how they can best cooperate with the workers to whom they entrust their children during their hours away from home.

Because of child supervision and other health services the public health nurse gives in many homes she is in an unusually favorable position for making the cen-

ter better known to the family and the home better known to the center.

Principally, what prevents mothers from working regularly outside their homes is acute illness of their children. Since sick children can not usually be kept in the center, care must be provided in their own homes, in foster homes, or in a hospital, or other health center outside the home. If a relative, neighbor, or housekeeper can stay at home with the child, the public health nurse may give hourly nursing care or teach others to give it under her supervision.

Public health nursing agencies are adjusting working hours so that families may be visited for service or consultation evenings as well as daytimes and Sundays.

VII. Helping to stimulate community interest in resources for providing care for children of working mothers

Voluntary or paid auxiliary workers can be trained to help care for sick children when they cannot be kept in day care centers. Red Cross Nurse's Aides and other volunteers in public health nursing agencies, women in the neighborhood who have demonstrated ability in the care of their own children or had a course in home nursing, housekeepers who have had some training in practical nursing—all should be considered in this connection.

The public health nurse has responsibility for preparing various auxiliary workers for nursing services in the home; for familiarizing families with ways of securing their services, and for supervising the care given by them.

Where care in their own homes or hospitals is not available for sick children of working mothers, the establishment of nursing centers where several children can be cared for has been considered in

PUBLIC HEALTH NURSING

some communities. Where centers of this kind seem to be needed, the public health nurse can make it known to the health authorities and to civic groups. She can help to locate and equip such centers; find the necessary nursing personnel; and supervise the nursing care given by

auxiliary workers. This type of center or infirmary may be particularly practicable where there is unusual shortage of medical and nursing personnel and where housing is unfavorable for care of sick children—trailers, shacks and rooming houses.

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An Analysis of Rural Nursing Services

By CARL A. SCHERER, M.D.

ANYONE responsible for the administration of a health unit must wonder whether the nursing services rendered measure up to his own ideals and are satisfactory to those to whom he is answerable. In considering the distribution of services he must necessarily take into consideration special health needs of the community in order that proper emphasis may be laid. But even these cannot be allowed to disrupt the balance of the general public health program too much. Such speculations led the administrative officer of Rural Health Unit No. 4, Minnesota Department of Health, to attempt an analysis of the activities of the field nurses of the district, based upon services recorded on their daily reports. The object was to show: (1) the amount and type of work done by the field nurses (2) the balance of the program in accordance with the needs (3) the distribution of the services to individuals and (4) the distribution as to locality in the area where the nurse worked. Incidentally, the tabulation showed the economic status of the recipients and the source of the call that prompted the service.

The district is made up of three counties: one with an area of 860 square miles and a rural and small-town population of 16,048; the second, 1,403 square miles and 3,030 population; the third, 9,611 square miles and the total popula-

tion 206,917, of which only the rural population of about 40,000 is included in the unit. The total area of the district is 8,874 square miles and the total population served by the unit 59,078 (1940 census). No urban area over 2,000 population is included in the nursing service. The staff consists of a full-time medical director, a supervising nurse, a public health engineer, a dentist, eight field nurses and three clerks. There is a central headquarters office and five field offices in various parts of the district. There is a distinct difference in the type of service rendered in each of the three counties, dependent upon the density of population, the physical characteristics, and policies predetermined because of need. These are brought out quite definitely in the analysis and will be discussed. To give a more complete picture of the district a table is included showing area and population of each nurse's field, the miles travelled, the number of homes visited, and the number of hours on duty during the year. (Table I).

These figures represent experience for the calendar year 1941. A numerical code based upon the code used in the standard monthly nursing activities report form was devised to facilitate mechanical tabulation. The nurses' reports of their daily activities, made on a special blank, were received at the central office once a week and immediately punched on tabulating cards. A monthly

TABLE I
DATA ON THE AREAS IN WHICH NURSES WORKED WITH TRAVEL, HOURS ON DUTY AND
NUMBER OF HOMES VISITED

	Total district	Nurse 1	Nurse 2	Nurse 3	Nurse 4	Nurse 5	Nurse 6	Nurse 7	Nurse 8
Area (sq. miles).....	8,882	1,732	2,066	795	648	1,082	684	472	1,403
Population	59,078	6,290	6,954	6,030	10,220	8,571	6,673	11,310	3,030
Miles travelled.....	115,160	27,980	18,311	11,990	10,050	12,551	9,617	13,488	11,173
Hours on duty.....	16,606	2,480	2,184	2,131	1,798	1,876	1,639	2,309	2,189
Homes visited.....	6,141	773	981	522	1,158	615	484	503	1,105

run-off of the reports was used to replace the standard monthly form. Quarterly summaries were run. Tabulation equipment and personnel were made available by the auditor of St. Louis County. The study confines itself to the services of the field nurses only, because the activities of the public health engineer, supervising nurse, dentist, and health officer would have necessitated separate and entirely different codes.

The usual activities of the public health nurses may be divided roughly into: (1) individual contacts, such as visits to homes, visits to schools, office consultations and consultations with physicians in behalf of patients (2) group activities, such as inspection of school children, participation in mass immunization and vaccination programs (3) miscellaneous administrative and educational activities, including various phases of health education such as talks, classes, exhibits, movies, distribution of literature. These activities are directed in varying degrees of concentration toward the following purposes, which may be considered to constitute the essential framework of a public health nursing program: communicable disease control, venereal disease control, tuberculosis control, maternity service, infant and pre-school hygiene, school hygiene, adult hygiene, morbidity service, crippled children's service, and social service.

In order to visualize nursing activities

for purposes of comparison, it is necessary to formulate several basic tables. Accordingly, Table II is constructed to show the actual number of contacts that each field nurse of the district had during the year with individuals in her nursing area. These contacts must be broken down into the various essentials of the accepted framework in order to determine the degree of balance. The breakdown is shown in percentage to facilitate comparison. For the purpose of further comparing the work of the eight nurses, the volume of group activities is recorded in Table III. To appraise fully the value of a nurse's work, her efforts in health education as well as in individual and group services must be analyzed. Since it was found difficult to separate definite health education activities from the incidental administrative procedures, such as meetings attended by the nurse and conferences held by her, these items are shown together in Table IV. Attendance at classes and public health talks, as recorded, is probably the best available measure of the value of teaching.

Before attempting a study of Table II, it may be well to look at the factors that must be taken into consideration before evaluating the services of each nurse by purely numerical deductions. There are many such factors. To list a few:

1. Predetermined differences in the policy of the nursing area.

2. Differences in actual need in the area.
3. Density of population and size of the area.
4. Mileage allowance as affecting travel.
5. Time off duty and change of nurses in area.
6. Number of schools in nursing area.
7. The possibility that a nurse's attitudes and interests influence her services.

In fact, in considering extraneous factors it is quite probable that the interests, abilities and personalities of the administration and supervision influence the balance of the entire program of the district.

As for Table II itself: It shows that the nurses made 10,627 contacts with individuals in the twelve-month period. On the face this appears to be eminently satisfactory, but this is a total. Did all the nurses carry their part and if not, why not? Is the distribution of these calls such that a well-balanced program was carried out in each area? In the study of the table it will be seen that there are definite variations. All of these can be explained by the factors enumerated above. Furthermore, many of

the inequalities are counterbalanced by the greater amount of group work done by certain nurses. Communicable disease naturally varies with the actual number of cases and during the year when this study was made they were low. Morbidity was done only as demonstration or at the request of a physician. Social service was usually referred to the welfare departments of the three counties.

As for the work of the individual nurses: Nurses 1 to 5 worked in the largest county directly under the supervision of a county supervising nurse and a full-time health officer. Nurse 4 had a small area with concentrated population. The tabulation for Nurse 5 is low because there were actually two nurses with an interval of about four weeks without a nurse in the area. The tabulation for Nurse 6 also reflects a change of nurses. The nurse originally in the area became ill, took two weeks' sick leave and resigned; as a result the area was without a nurse for two weeks more.

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Number of services									
for all purposes	10,627	1,496	1,557	1,248	1,746	901	1,005	931	1,743
Percent of services for									
all purposes	100%	100%	100%	100%	100%	100%	100%	100%	100%
Communicable									
disease control	11.4	7.4	5.6	9.3	16.4	8.7	11.6	17.6	14.7
Venereal disease*	0.5	0.1	0.6	0.7	0.1	0	0.4	0.1	1.3
Tuberculosis	15.1	14.8	21.9	20.2	11.2	2.2	29.2	6.7	2.5
Maternity	9.6	8.2	8.6	6.0	15.0	5.4	5.9	4.8	15.4
Infant and preschool	27.8	43.0	20.3	19.4	37.0	27.5	18.1	24.2	25.8
School hygiene	9.9	10.3	7.3	19.6	10.2	7.9	12.7	15.7	1.3
Adult hygiene	5.3	4.5	12.5	5.5	1.2	9.9	3.5	8.1	0.8
Morbidity service	14.7	4.7	13.5	15.0	7.2	11.5	13.6	9.5	36.4
Crippled children	4.4	6.3	6.6	3.7	1.1	5.6	3.8	10.1	1.2
Social service	1.3	0.7	3.1	0.6	0.6	1.3	1.2	3.3	0.6

* Venereal disease activities carried by state medical social worker.

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School hygiene.....	9.9	10.3	7.3	19.6	10.2	7.9	12.7	15.7	1.3
Adult hygiene.....	5.3	4.5	12.5	5.5	1.2	9.9	3.5	8.1	0.8
Morbidity service.....	14.7	4.7	13.5	15.0	7.2	11.5	13.6	9.5	36.4
Crippled children.....	4.4	6.3	6.6	3.7	1.1	5.6	3.8	10.1	1.2
Social service.....	1.3	0.7	3.1	0.6	0.6	1.3	1.2	3.3	0.6

* Venereal disease activities carried by state medical social worker.

PUBLIC HEALTH NURSING

Nurse 7 had a large scattered population, numerous schools located in small villages. Nurse 8 has only about 3,000 people in a vast area. For demonstration purposes her services included bedside nursing, delivery service and weekly clinics at an Indian reservation. There was only one physician in the area and the nearest hospital is 100 miles away. When all these factors are taken into consideration the apparent discrepancies in the balance of the individual programs are less significant.

Tables III and IV show the group work done by the eight nurses. Here again extraneous factors must be taken into consideration. The number of schools and school population, the number of clinics and the convenience to medical care all influence the group activities carried out under these classifications. Nurses 5 and 8 had but few schools with a small school population. Nurse 7, whose number of individual calls was comparatively low, had a large number of schools and did a great deal of school work. It is to be regretted that for purposes of individual record this group work was not listed by individuals. This was omitted because im-

munizations, vaccinations, tuberculin testing, school inspections and examinations by physicians were already recorded in the individual school cards, which are kept in duplicate, also on an annual summary sheet and the original consent slips. However, it is now recognized that a more complete evaluation of the complete nursing program would have been possible had this information been punched on the tabulating cards.

Table IV, listing miscellaneous activities, shows quite a wide variation in the public health talks and number of classes conducted by the nurses. This is probably due entirely to the nurse's personal attitude. It is to be noted that these variations counterbalance the variations of the number of individual contacts in Table II. Thus it is emphasized that each nurse exerted an appreciable degree of independence in distributing her efforts from which considerable variation resulted. From the standpoint of specific types of miscellaneous activities it is noted that the number of meetings attended by the nurses are practically the same throughout. Nurse 8, far from a medical and nursing center, did not have the opportunity to attend as many

TABLE III
GROUP SERVICES (ASSISTING PHYSICIAN IN IMMUNIZATION, VACCINATION, TUBERCULIN TESTING, PHYSICAL EXAMINATIONS, AND MAKING PUPIL INSPECTIONS)

All nurses	Nurse 1	Nurse 2	Nurse 3	Nurse 4	Nurse 5	Nurse 6	Nurse 7	Nurse 8
39,827	5,825	3,811	4,501	5,903	1,661	5,285	7,695	2,641

TABLE IV
MISCELLANEOUS ACTIVITIES

	All nurses	Nurse 1	Nurse 2	Nurse 3	Nurse 4	Nurse 5	Nurse 6	Nurse 7	Nurse 8
Classes conducted....	247	11	45	22	47	28	19	59	16
Attendance	3,712	131	628	351	689	319	203	1,050	341
Talks made.....	162	19	47	27	22	19	13	11	4
Attendance	7,123	1,199	1,682	1,396	605	648	358	949	286
Meetings attended..	270	41	35	37	35	39	32	33	18
Conferences held	2,731	240	217	282	413	185	473	798	123

RURAL NURSING SERVICES

meetings as the other nurses. As for conferences held, it is to be expected that Nurse 7, due to the large amount of school work, would have many conferences in behalf of service with school authorities.

The 10,627 services were rendered to 6,736 individuals, approximately 11.5 percent of the population of the three counties, each of whom received on an average of 1.6 services. Analysis of the service to the individuals shows:

- 56.4 percent—1 call only
- 22.7 percent—2 calls
- 10.3 percent—3 calls
- 4.8 percent—4 calls
- 2.5 percent—5 calls
- 3.3 percent—6 plus calls

The fact that 3.3 percent received six or more calls is influenced by the fact that Nurse 8 did bedside service. Most of the other plural calls show that a variety of services were rendered to the individuals.

The fact that slightly more than 10 percent of the population was contacted by the Health Unit in individual services is further borne out by the tabulation of locality where the service was rendered. To obtain this information the nurses' daily reports showed numerically the township in which the service was rendered. A map of the counties, with the population in each township, was used to enter the quarterly tabulation of this locality. The totals at the end of the year gave a surprisingly even distribution of about 10 percent of services per population of each township served.

The economic status of individuals receiving nursing service was listed as direct relief, six different types of indirect relief, such as W.P.A., aid to dependent children, and so on and borderline and independent. Naturally no record was kept of the economic status of people with whom conferences in behalf of service were held, such as teach-

ers. In an analysis of this, we find that 65 percent of the clientele of the Health Unit were independent or borderline. It must be kept in mind that all relief cases were referred to the county welfare boards.

While there may have been some difficulty in recording the source of call—that is, at whose behest the nurse made the call, since second or third calls may have been made at her own initiative—the fact was revealed that the health department was not working in as close cooperation with the medical profession as might be desired, since a very small percentage of the calls originated from physicians.

It must be kept in mind that this device does not attempt to measure the quality of a nurse's work. We believe that this can best be judged by proper supervision and by contacts of the supervising personnel with the nurse in the field.

WHAT DID THE STUDY SHOW?

The question of the actual benefits derived by the administration from the study herewith reported is naturally uppermost in the mind of the reader. Did the scheme answer the objectives enumerated in the opening paragraph? The tables and the discussion of them certainly present the actual amount of work accomplished, the balance of the program, and the distribution of services. The monthly tabulation of each nurse's activities required a minimum amount of study for a complete comparison, and shortcomings were easily detected. Overemphasis of certain phases of the program were soon called to the attention of the individual. The quarterly summaries gave a simple and complete picture of the nursing activities of the entire district. When an individual received a larger number of services than experience seemed to warrant, it came to our attention at once.

PUBLIC HEALTH NURSING

The question then arises whether this could not have been done as easily by the usual methods. As has been said, it was easy to read at a glance just how each nurse's work was getting along. The totals of various activities stood out prominently and were readily interpreted. The numerical code was considerably more simple and flexible than that generally used. Reports to the central office were quickly assembled and the margin of error was restricted entirely to the daily report sheets.

WHEREIN DID IT LACK?

The entire scheme could have been made more valuable if a consistent method of recording each individual served had been followed. Each person served in group work should have been given a case number and treated in the same manner as individuals served separately. As it is the tabulation is based entirely upon services rendered rather than upon individuals served, nor does the study bring out the correlation of the various services rendered to individuals within the staff itself and with

other cooperating agencies. That is, it does not show cases referred to other agencies or cases upon which the epidemiological and sanitary facilities of the staff were consulted. Furthermore, it does not bring out the time element in repeat calls; for instance, it does not show how many visits each infant received in the first year or first three months of life; also, group activities give no indication of the individuals contacted.

The tabulation was costly and the cost not commensurate with its value as a permanent evaluative arrangement. It may be practical for periodic analysis, but even then the cost of mechanical tabulating would probably be prohibitive in a small health unit. The periodic application of a simple evaluating process permitting hand tabulation of significant items and evaluation by use of an appraisal form is equally satisfactory.

The author is indebted to Dr. Joseph Mountin and Evelyn Flook of the United States Public Health Service for their suggestions and aid in the completion of this report.

ALL IN A DAY'S WORK

THE TELEPHONE at district nursing headquarters jangled insistently as though the operator was determined to arouse anyone who might be taking a siesta in the sweltering noontime heat. The secretary answered it.

"I must have a nurse emejatly! A baby's comin' right away!" an hysterical male voice at the other end of the wire shouted.

A nurse was located and sent post haste to the address given. There she was greeted by an agitated Negro who shouted with all his lung power, "Hallelujah! Hallelujah! I is sure glad to see you, chile!"

He was a clergyman and the patient a neighbor who had dropped in for a short visit when the unborn child decided to make its appearance. Baby and nurse arrived simultaneously so there was little time for extensive preparation. As busy as the nurse was she could not keep from smiling at the little minister as he scurried around bringing her supplies and exclaiming, "Hallelujah! Hallelujah! Why did God have to bring this baby to my house! Hallelujah! Hallelujah!"

—From the 1942 Annual Report, Newton District Nursing Association, Newtonville, Massachusetts.



The public health nurse looks the situation over, does what is needed—then writes it down in her little red book, or record-form if you will

Do Records Get You Down?

By MILLICENT KAY, R.N.

I CAN'T offer you magic pills to cure those "Recording Blues" but I can tell you about five magic words—WHO, WHERE, WHEN, WHY, and WHAT—that help to guide me in writing and using records.

Being a staff nurse, I face much the same problems and "headaches" as you, struggling from day to day and often wondering what I am accomplishing. Yet, believe it or not, when I write out records I'm encouraged because they show in black and white just what I have done—and left undone.

Let's face the matter squarely and forget our prejudices, whatever they may be. Some of you may be saying, "Hm! Impossible, I just don't like writing

records." Well, maybe you don't, but you'll have to admit there must be a reason for them when national organizations stress them to directors, directors stress them to supervisors, and supervisors pass the buck to us staff nurses.

So let's grant there is a reason, and that it has four aspects—administration, statistics, service to patients and time saving. Can we separate these aspects and say, "I am a staff nurse. I have nothing to do with administration or statistics. Those are the supervisor's and director's jobs." Let that argument be for the time being, but I wager I can convince you that we really are concerned with all four aspects.

Suppose we see what the five "W's"

PUBLIC HEALTH NURSING

have to offer in helping us write records. This is how they work for me.

WHO

Naturally you'll get the name of your patient. Do you always remember to get the mother's maiden name? It is very important to have that especially if you are clearing a family through a Central Exchange. I put the name of my patient on a 3 by 5 card, then flag it and file it in a metal drawer. This is how the card looks:

Murphy, Rose (birth)
123 Arbor Lane 2/12/42
Ruralville

I flag the babies with pink (you know they look so pink and white anyway). Then if I have to find out how many babies I am carrying, I merely count the flags. Other services and age groups have other colors. You can make your own color code if you are working alone, or your organization can decide upon a uniform code. That 3 by 5 card file is a big help in analyzing my case load. When I see a predominance of one color I quickly realize one service or age group is becoming top-heavy. On the other hand if I have only a few cards in a specific color, I know this group needs more attention.

WHERE

Do you remember the first time you went on a new district and thought, "Goodness, I'll never learn where all those streets and roads are." Perhaps all you had to go on was a street name, or maybe only the village. And what time you wasted looking for the patient's house! So, when I am checking over my records, I make sure I have the address and detailed directions for finding it, such as, Mary Jones, Apple Street, second house on left from Main Street, Ruralville. Usually I put this down immediately after I've made the call so I'll know how to get back there. It's a quick time-

saver. Probably most of you do the same thing, but just for fun look over your records and see if you have every address with directions filled in properly. Could another nurse take over without too much difficulty?

WHEN

The next "W" is, *when was this case opened?* Is it a recent case? If it is, it may require more frequent visiting than others. The young mother just back from the hospital with her baby may be glad of help soon, until she overcomes her natural nervousness in handling him. When she has reached the point of some confidence, then you can gradually space your visits further apart or possibly she'll be all right without any visits. Or maybe it was a case opened months ago at a time when the outstanding problem was helping to right a poor nutrition situation due to limited finances. Now you may find that the father is working in a defense plant and the family beginning to pull itself up by the bootstraps. The mother, having more money, is able to and is buying the right kind of food for her children. So you may be able to discharge this family from the active file. Or perhaps you have a family which has been a "borderline" case for years. Now it finds itself "flush" and the mother just buys and buys with no thought of food values! That's a more challenging and sensitive problem than you'd think at first glance.

I know by this time you may be saying "Hm! It isn't always as simple as that." Isn't it the truth! We all have a few cases in our files whom we just can't teach no matter how hard we try. Every once in a while we take out their records, heave a sigh and think, "What on earth can I do here?" Well, probably there isn't much you or anyone else can do. We are not superhuman. Why not summarize your attempted help and failures and state why the case is being closed

RECORDS GET YOU DOWN?

or discharged. If another acute problem arises in this family in the future, it will be easy to re-admit it, and you—or your successor—will have some data to go on.

I guess you know what I am driving at by now, namely that the date when the case was opened, placed in its proper space will give a clue about whether this case has any right to be in the active file, whether it calls for a concentrated job of visiting or only widely spaced periodic visits. And while we're on the subject of "dates" do you have all the birthdays and other "date data" filled in? See how your records rate on that!

WHY

The *why* in the five "W's" is quite a time-saving factor and serves a statistical purpose too. Have you any dead wood cluttering up your files and mind? You know the cases I mean, those of which you say, "Goodness, I must try to get in to see Mrs. Alright soon." But somehow with the pressure of more important things you never do it. But the record in your file moves back and forth from month to month. Look these cases over. Then dismiss them to the discharged file and leave your mind free for more active cases. When you visit them you may find they have a new problem which will call for concentrated help or teaching. If the various Mrs. Alrights have no problem which requires your help, get in that planned visit to make sure. At any rate, have a reason for taking up a case and keeping it in the active load—in other words *why was this case opened?* Is this reason or the existing problem on the record? What is the difficulty as the mother sees it, and what is it from your viewpoint? Do your records contain all the pertinent data? If they do, they are workable.

As to the statistical purpose the "why" serves, that's simple. When you make out your monthly report, you have to

state the number of cases carried in the various services. This "W" puts the cases into their proper service. If you have the case for health supervision, it goes under that heading; if for prenatal care, under that, and so on. So you see, statistics are not boring. They are figures revealing how we staff nurses balance our service load.

WHAT

After you have eliminated all but the active cases on hand comes the last but really the most important "W." *What is being done here?* Is this family gradually learning to stand on its own feet from a positive health angle? Is the antepartum case under a doctor's care yet? If not, why? If she doesn't have the money, have you referred her to the proper social agency for aid? Is there a case of tuberculosis in the family? Can you persuade him to follow the doctor's advice and go to a sanatorium? If he refuses, have you taught the family and patient good communicable disease technique? Have the contacts been X-rayed? Have you incorporated all these facts in your records? Then the pre-schoolers' health supervision. Have they been immunized? How do they get along with other children? Are they being prepared for school? Can they help dress and undress themselves? Are they gradually learning to become independent little people? Is their diet satisfactory? Just how much rest do they have during the day?

And how about your service to the babies? Do you sometimes wonder, if you haven't been in the field very long, just what this service covers? Have you succeeded in getting the mother to take the baby regularly to the doctor? Is the food gradually being increased to meet the demands of a growing infant? Have you written down exactly what the feeding is so that when you analyze the individual infant's record you can actually see the

PUBLIC HEALTH NURSING

development from month to month? Writing in the baby's age at the beginning of your entry is a handy habit to acquire. Then when you look at the record, you can immediately determine if the baby is developing normally for his age. Do you write in, "Discussed diet with mother"—period? Or do you add what decisions the discussion resulted in—"Mother will try cooking fresh vegetables a shorter time, and making a milk custard."

Are you on the lookout for any possible physical defects? Watch little Bobbie walking. Does he have the normal gait of a three-year-old or does he have a peculiar duck waddle, stumbling and falling too much? What's being done for the little fellow who had rheumatic fever? Do the school authorities know about him? Is he getting all the rest he should?

These are just a few of the things that you and I observe hourly and daily . . . but do we include them in our records? We don't have to write a long story. Facts are all that are needed. You remember the aviator who flashed back, "Sighted sub, sank same," a complete picture in four words. Save time by writing specifically. Most visits could be boiled down to a few words or sentences. Tell what the need is, your observation about it, and "what" is being done. But—here's the catch—are we really being observant all the time? Do we take time to stop, look, and listen?

Now let's wait a minute and catch our breath. What have I said that you didn't know already? Nothing! The only specific thing is the five "W's." You'll notice that I've said very little about the details required on all records. Yours are different from mine and there is no point in trying to enumerate them all. I have discovered that when I take care of the data which seem important to me, the details have a way of taking care of them-

selves. You just can't help getting all of them—not on the first visit I agree, because then you are too busy trying to establish a good contact and win the confidence of the individual. As you become better known to the patient, questions and the answers will come.

Are you beginning to wonder if I am going to say something about *service to the family*? This after all is the reason for our being on the job. Well, I feel that if you have done a good job of the five "W's" you *are* improving your family service. The records show the problem and progress being made. When you check them over you see what you've done and where you've fallen short.

Have I proven my argument? You plan and organize your work from day to day, which is administration in your own line of duty. You make a comparison of your work from month to month and from year to year, and what is that but statistics? In 1941 you did so, and in 1942 you bettered your record. What will your statistics show for 1943? As you go over your records occasionally you will find yourself analyzing them to yourself with varying comments. As you observation becomes more keen, and your record-writing more pertinent, you will find that your service to the family is improving. Furthermore your records will be functioning as tools and that is what they are for, because they will save your time and also that of a relief nurse who may have to pinch-hit for you. Then if or when your successor takes over, she will find WHO the patient is, WHERE she lives, WHEN the case was opened and last seen, WHY the case was opened in the first place, and WHAT was done. She will say thankfully, "That nurse surely knew how to handle records without letting them get her down."

Picture by MALAK, Canada.

Better Care for the Patient with Syphilis or Gonorrhea

By EVANGELINE H. MORRIS, R.N.

AN ANALYSIS has been made of reports from some 2,000 syphilis clinics in 30 states throughout the country. Lida J. Usilton said, "This analysis showed that only 25 out of every 100 patients with early untreated syphilis admitted 19 to 24 months prior to the analysis had received 20 injections of an arsenical and 20 of heavy metal. This means that by the most liberal of standards—a minimum amount of an arsenical and heavy metal administered in the longest permissible period of time—not more than 25 out of 100 patients are held through a relatively uninterrupted treatment course."¹

Both from the point of view of protecting the family and the community and also in the best interests of the patient's complete recovery, these figures represent a deplorable situation. It has long been conceded by the ablest syphilologists that "continuous treatment in adequate dosage is essential for the cure of early syphilis."² Comparable figures concerning the number of patients with gonorrhea who fail to remain under treatment long enough to receive the benefits of effective chemotherapy are not available. Probably the experience of the young health officer in the South who remarked cynically that the lapse rate among his clinic patients with gonorrhea was perfect—100 percent—is not unique. The objectives of continuous adequate therapy are essentially the same for this group of patients as

they are for those who have syphilis and the failure to attain these objectives is again due to the fact that patients do not remain under treatment.

It is not the purpose of this paper to analyze the reasons back of these failures but rather to answer the questions so frequently raised by public health nurses, What do these patients need beyond specific therapy? Granted that we are fortunate in having specific therapy now freely available for the treatment of both syphilis and gonorrhea, there remain two contributions to the ultimate cure of these infections. Both of them should be the grave concern of our professional group: first, the development of those nonspecific factors which help the body to marshal its own defense forces, and, second, the education of the individual—to enable him to live intelligently with his infection and to prevent its spread to others. The literature on the broad aspects of the control of genitoinfectious disease contains a wealth of material on diagnosis, therapy, epidemiology, incidence and prevalence, morbidity, and pathology, but almost nothing on important supportive measures, and less on positive motivation through educational effort.

BUILDING THE PATIENT'S DEFENSES

It therefore seems advisable to quote directly the following significant statements made by outstanding authorities on this subject:

Stokes.³ "Into the care of the syphilitic patient and his recovery there enters an element of general resistance, difficult to define exactly, but none the less important. . . . Regular and sufficient sleep, regular eating, moderation in exercise and pleasure, every effort to allay worry and to ease nervous anxiety and stress, contribute to the rebound of the patient from the depressing effect not only of the disease itself, but of his knowledge that he has it. Alcohol, tobacco and sexual activity must be restricted. A gain in weight is often desirable."

Scholtz.⁴ "In the treatment of both early and late manifestations of syphilis, the level of general health, nonspecific immune factors and other unknown forces are of greatest importance."

It is less easy to get equally definite statements from authoritative sources concerning the importance of nonspecific care for the patient with gonorrhea. Pelouze⁶ has long emphasized that cure in gonorrhea is brought about by the development of natural resistance. Several specialists in this field reporting on the use of the sulfonamides mention that the patient may continue his usual activities and may continue to consume his regular diet.

Diet

This brings us to a consideration of the most important of the defense factors—nutrition. How good is this regular diet of our patients with genitoinfectious disease? They represent a cross section of the total population. We may assume, therefore, that a large percentage are malnourished.⁷ This would be especially true among individuals with neurosyphilis. Tabetics frequently show a marked loss of weight and are subject to anorexia. Yet it has been demonstrated that their best response to therapy occurs when there is a definite gain in weight. Several clinics,

including the University of Pennsylvania, recommend for the patient who is receiving an arsenical a diet rich in protein, containing meat, eggs, butter, milk, and cream. But this is expensive and it becomes increasingly difficult for the families with limited incomes to secure even a minimum of such foods. The majority of our patients have a diet which is heavily weighted with starches and sweets, the very things that they are asked to avoid. Several years ago, a local clinic discovered that more than half of its congenitals were definitely malnourished and that prior to the period of the study no diet teaching had been done with that group or with their mothers. And this in spite of the fact that in the same community, the services of a well-trained staff of nutritionists were freely available. Indeed, at that very time, the nutritionists were particularly interested in reaching such groups of handicapped children. How often this situation has repeated itself and how seldom have we done anything about the nutritional status of these patients?

Rest

A second defense factor of great importance is that of rest. And at this particular time, we are faced with the fact that a good many of our patients have a tendency to overwork and that an equally large group of them are under additional stress and strain due to the influence of the war. Any nurse who has worked with these patients either in the clinic or in the home is well aware of the fact that the very necessity of attending a clinic with the usual long delays in receiving treatment plus the complications of travel on our overloaded transportation systems add greatly to the expenditure of energy beyond the level which promotes recovery. Part of this unfavorable condition is beyond our control. Many of our patients

will continue to overwork. Some of them, however, need only be helped to organize a better plan of the day's activities or to make a fairer division of responsibilities within the family in order to find time to rest.

Other Factors in Personal Hygiene

It seems reasonable to believe that the abstractions usually labelled personal hygiene may also play an important though subsidiary role in the development of resistance. Many of our younger patients with genitoinfectious disease have not established satisfactory health habits. Their concepts of what constitutes good personal hygiene are exceedingly vague. Changing these vague concepts into definite ideas of what to do and when and how to do it is a worthwhile undertaking. An improved feeling of physical well-being will be a logical result, and this in turn may help to overcome a sense of social inferiority, a concomitant often overlooked with these patients. It has been my personal experience that this teaching is valuable not only for its intrinsic worth but also as a direct answer to the patient who, having been told to give up this and refrain from that, says in despair, "What are the things I can do?" As a part of our personal hygiene teachings, an emphasis may well be placed on dental care. A study of the dental aspects of congenital syphilis conducted by Brauer and Blackstone⁸ gives interesting information relative to the incidence and type of dental stigmas in this group and indicates that deciduous as well as permanent teeth may be adversely affected. Patients in this group as well as those with acquired syphilis who are receiving heavy metals need to be reminded frequently of the importance of oral hygiene.

Relief of Pain

It would be difficult to prove that the relief of pain promotes recovery from in-

fection, and yet it may be conceded that either physical or mental suffering is a deterrent force in response to therapy. We are so accustomed to seeing our patients ambulatory and in fairly good condition that we often fail to notice their discomforts or distress. The pain associated with interstitial keratitis with certain secondary manifestations, with the acute stages of gonorrhea, with occasional reactions to the arsenicals, with gonorrheal arthritis, and particularly with the exquisite anguish of the tabetic with a gastric crisis is all too frequently ignored. Some of these conditions cannot be relieved, many will respond to special treatments. All may be at least temporarily alleviated by sympathetic understanding care. Alphonse Daudet's⁹ statement, "Pain is always something new for him who suffers but banal for those about him. They will all get used to it except myself," is worthy of our serious consideration.

THE PATIENT'S EDUCATION

The second contribution to the ultimate cure of the individual patient is his education. Too frequently we have considered our educational objective accomplished when we provided the patient with a set of facts which he little understood and seldom used. Lena R. Waters expresses the situation well when she says, "The patient has a serious illness which is not understood either by himself or by society."¹⁰ Ignorance is the forerunner of fear, which may manifest itself in various unfortunate ways. These fears may be assuaged by a calm unemotional approach, by teaching and by frequent repetition of that teaching. There is a dual purpose in this teaching: first, to enable the patient to live intelligently with his infection; and, second, to prevent its spread to others. The first objective may be attained by repeated emphasis

PUBLIC HEALTH NURSING

on the fact that in early syphilis and acute gonorrhea, life is only temporarily disturbed; after adequate treatment, the patient may well anticipate a normal life and a return to good health—that in late cases of either syphilis or gonorrhea, life is relatively unchanged except for treatment. The second objective is reached only when we have secured the cooperation of the patient. He needs to know in terms which have meaning for him as an individual how long his infection will be communicable, how it may be transmitted to others, how to use protective measures. More than this, he needs to be understood as a member of the human family. This understanding will often enable him to face his problems realistically and to modify his behavior in the interests of others. This tremendous task of changing habits, of modifying behavior, of helping patients to build new and better attitudes will require time and skill and patience. It can be done, however. Public health nurses are daily performing such miracles.

When we supplement the use of arsenicals and heavy metals for syphilis and the use of sulfonamides for gonorrhea by a better program of total health for the patient, and when we have used educational measures to promote his better understanding and to secure his cooperation, we will be well along the way to that more effective program in which we are all profoundly interested. Such a program embracing all the components of total optimum care will succeed in keeping more than 25 percent of our patients under care and will eventually cut down on the number of new infections. Its execution does not call for a corps of specialists. Its content should become an integral part of the work of every public health nurse in the country supplementing case-finding activities, diminishing the necessity for follow-up, and completing family health service.

See also Mrs. Morris' letter to PUBLIC HEALTH NURSING, page A3.

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How Do Recent Presidential Orders Affect Nursing Agencies?

PUBLIC health nursing agencies have long been accustomed to accounting to their communities concerning such things as amounts and kinds of service rendered, income received, and money expended. But it is a novel and somewhat confusing idea that now, because of wartime conditions, they must also account to their Federal Government for salaries paid, and in many areas for the minimum work week of their employees.

Three presidential orders issued in recent months have implications for public health nurses and public health nursing agencies:

1. Executive Order 9250—freezing salaries.

2. Executive Order 9301—establishing the 48-hour minimum work week in certain areas.

3. Executive Order 9328—commonly known as the Job-Freeze or “Hold the Line” Order.

1. Wage Stabilization Executive Order 9250 (October 3, 1942), Clause I, Title II, reads as follows: “No increases in wage rates granted as a result of voluntary agreement shall be authorized unless notice of such increases have been filed with the National War Labor Board and unless the National War Labor Board has approved such increases.” This order does not apply to salaries of public health nurses working in official agencies nor to those in nonofficial agencies with less than eight full-time employees.

The regulation permits increases made in accordance with terms of established

wage or salary agreements or established wage or salary rate schedules (without necessity of specific approval) if the raise is in one of the following classes:

- a. Individual promotions or reclassification at higher wages.

- b. Individual “merit increases” within the pay ranges already established by the employer for the particular kind of job.

- c. Increases under established plans based on length of service (where the employee is scheduled to get higher salary at the end of each six months or year or some other period of service.)

- d. Increased payments based on greater productivity under piece-work or so-called incentive plans.

- e. Increases under an apprentice or trainee system—where an employee gets higher pay after a period of training.

In case a public health nursing agency wishes to adjust its salary scale upwards, approval must be obtained from the regional offices of the National War Labor Board. Advice concerning this matter may be sought from the Wage and Hour Division of the U. S. Department of Labor in each state. Regulations of the Bureau of Internal Revenue apply to salaries over \$5,000.

2. Executive Order 9301 issued by the President on February 9, 1943 established a 48-hour minimum work week wherever the War Manpower Commission deems it necessary as part of the fullest mobilization of manpower. Shortly thereafter 32 labor-shortage areas were designated by the War Manpower Commission, in which the 48-hour week was established as of March 31. It seems likely that all parts of the country may soon be included. This ruling

PUBLIC HEALTH NURSING

also applies only to employees in organizations with more than eight people and excludes state and local government employees, except that these may be included by state or local government action.

Where the 48-hour week will not result in release of workers, it can be adopted without notice to the local War Manpower Commission. If it results in release of workers, notice must be given to the local War Manpower Commission, and current work projects continued until instructions are received.

Local health and social agencies operating within a single state do not come within the Wage and Hours Law and are not required to compensate for additional hours of service save where such compensation is required by state laws or schedules or agreements within the agency.

3. Executive Order 9328, which is the most recent government order affecting public health nurses is the "Job Freeze" order of April 8, 1943. This was followed on April 18 by Regulations of the War Manpower Commission restricting the transfer of workers, also by a directive on May 12 by the Director of Economic Stabilization which interpreted Order 9328 and somewhat modified its severity. According to this combined authority employees cannot leave their jobs in an essential activity for an unessential activity, or for a job in an essential activity at a higher salary, without a certificate of availability from the U. S. Employment Service. The War Labor Board, as under Order 9250, was authorized to adjust gross wage inequities, make adjustments in line with the cost of living and adjustments required for more effective prosecution of the war.

The War Manpower Commission has prepared a list of 35 essential activities and industries which includes under "Health and Welfare Services":

Offices of physicians, surgeons, dentists, oculists, osteopaths, podiatrists and veterinarians; medical and dental laboratories; hospitals; *nursing service*; institutional care; auxiliary civilian welfare services to the armed forces; welfare services to civilians.

A new position can be taken, according to Order 9328, whenever the worker (1) is discharged by his last employer (2) is laid off for an indefinite period or for a period of seven or more days or (3) can establish that his present employment does not utilize him at his highest skill or that he is not being employed at full time.

The "Job Freeze" order is so recent that little experience of its application to health and social agencies is yet available. It applies to all agencies public and private.

With regard to salaries experience thus far indicates that there has been little difficulty in raising salaries in public health nursing agencies because of increase in cost of living, if taken up with the War Labor Board. Recently, consideration of such requests has been interrupted because of the "Job Freeze" order and its close relation to salaries.

The 48-hour week has already been adopted by some public health nursing associations in critical labor shortage areas. Exceptions can be secured in cases where "(1) a 48-hour week would be impractical in view of the nature of the operations (2) would not contribute to the reduction of labor requirements or (3) would conflict with Federal, State, or local law or regulation limiting hours of work." Some associations have made application on these grounds for permission to continue with a minimum work week which is less than 48 hours.

Though public health nursing associations are not required to compensate for additional hours of work as stated above,

PRESIDENTIAL ORDERS

there are obviously good and practical reasons why increased compensation should be provided. This presents a difficulty to many agencies willing to increase their work week in order to make the fullest use of nursing and other personnel in this time of shortage but whose income is not sufficient to pay for the increased number of working hours.

With regard to all three of these orders, it has been suggested at various times that national bodies such as the N.O.P.H.N. or the National Social Work Council might request exemption for local agencies in their respective fields. However it is the consensus among national agencies that there is no very good reason for general exemption and that interpretation of the orders as they apply to this type of organization is instead needed.

Effectuation of Executive Orders 9301 and 9328 is the responsibility of regional directors of the War Manpower Commission, and Order 9250, of the War Labor Board. Councils of Social Agencies are in some communities acting for their members in securing such interpretations. Whether acting as one of a

group or as an individual agency, a necessary first step when faced with problems related to frozen salaries, frozen personnel or requirements for increased working hours is to consult with the regional office concerned. Application of orders may vary with varying conditions in employment stabilization areas in different parts of the country.

It should be remembered that the purpose of all these orders is to increase industrial production. There is no wish on the part of government to hamper the work of health and welfare agencies.

Charles P. Taft, director of Community War Services in the Federal Security Agency, frequently dealing with other governmental departments in regard to the effect of their regulations on problems of health and welfare agencies, has said he will be glad to know of specific cases where manpower regulations under the "job freeze" order, or the 48-hour week application, or regulations of the War Labor Board or the Bureau of Internal Revenue in regard to salary stabilization, have caused definite injustices and hardships.

R. H.

THE AMERICAN JOURNAL OF NURSING FOR JUNE

Trailer Town.....	Dorothy Deming, R.N.
Cancer of the Mouth.....	Charles J. Miller, M.D.
Nursing in Cancer of the Mouth.....	Josephine A. Flood, R.N.
This Waiting War.....	Edith A. Aynes, R.N.
Postwar Medical Reconstruction.....	Mary Elizabeth Tennant, R.N.
Spontaneous Pneumothorax—Nursing Care.....	Blanche Godfrey Smith, R.N.
Local Nursing Councils and the USES.....	Helen H. Ringe
Nursing Care of Newborn Infants	
A Children's Psychiatric Service.....	Ruth J. L. Gilbertson, R.N., and Helen Sutton, R.N.

What the Records Committee Does

BECAUSE the magazine is emphasizing cost analyses and records in this issue it is appropriate that the work of the Records Committee of the N.O.P.H.N. be described. The Committee came into being in 1913 and was called the Committee on Records and Statistics. The name of the Committee appears as "Committee on Records" in 1925, at which time a group of statisticians were appointed as advisers. From 1929 to date this group has been called simply—"Records Committee."*

The functions of the Records Committee as prepared by the Committee and approved by the Board of Directors on January 16, 1930, are:

1. To set forth and define such of the accepted functions of public health nursing as are needed in reports for administrative and statistical purposes of agencies engaged in public health nursing.
2. To work out the essential content of record forms and reports for these purposes.
3. To draft approved record and report forms, and to prepare instructions for use of forms and for compiling and presenting the data asked for.
4. To serve in an advisory capacity to other committees of the organization or outside group in the matter of form and content of records and reports.
5. To assist in efforts to coordinate public health nursing statistics with those of other health and social agencies.

*The present Records Committee includes as members: Chairman, Marie L. Johnson, Margaret G. Arnstein, Lola Beagle, Carl E. Buck, Dr.P.H., Hedwig Cohen, Ruth Fisher, Marjorie Gooch, Ph.D., Anna C. Gring, Anna T. Hooley, Gertrude Lyons, Amelia M. Meyersieck, Fred Laurence Moore, M.D., Rosalie I. Peterson, Dorris Weber, Dorothy E. Wiesner, Secretary.

These functions were reviewed by the Functions Committee appointed by the Board of Directors in 1936 and it was recommended they remain unchanged.

Many points of view have been represented on the Committee. Nurses from large and small agencies, from official and nonofficial, from conservative as well as progressive, plus statisticians and other interested nonmembers have debated terminology, emphasis, and form. The first set of N.O.P.H.N. record forms was published in 1919. From this time up to about 1930 the "check" system was popular. This gave the nurse certain columns in which she could enter a mark to show the subjects covered at the visit. In recent years the nurse's narrative report rather than the check system has received more consideration. From 1935 to 1940, the Records Committee revised the forms and added some new ones. The present nurse's daily report form was among the first to come from the Committee. Among the new forms are the General Health Service Record and the Labor and Delivery Record. In PUBLIC HEALTH NURSING of January 1941, Katherine E. Peirce, chairman of the Records Committee from 1936 to 1940, outlined the principles which guided the Committee, and the possible adaptations by individual agencies.

The first comprehensive handbook on records prepared was based on five lectures delivered before the Department of Nursing and Health, Teachers College, Columbia University, in 1921 by Louis I. Dublin, Ph.D. In 1932 the U. S. Children's Bureau published a

RECORDS COMMITTEE

handbook on records and statistics, hoping that public health nursing agencies, particularly those submitting monthly reports to the Children's Bureau, would be helped in producing more comparable case and visit figures. This handbook was prepared by a joint committee of the N.O.P.H.N. and Children's Bureau's Advisory Committee on Social Statistics.

Working with the Records Committee on projects of joint concern is another N.O.P.H.N. committee—the Committee on Cost Analyses. Members of this group were the chief motivators in the preparation of "Principles and Practices in Public Health Nursing, Including Cost Analysis" published in 1932. The Cost Analyses Committee, at that time called the Service Evaluation Committee, used definitions of visit, case and related items formulated by the Records Committee in studying data from 24 associations to investigate methods of calculating cost per visit.

A Committee on Records and Reports to State and Territorial Health Officers and the U. S. Public Health Service drew up a tabulation blank in 1936 upon which statistics of Health Department Services could be entered. Two Records Committee members acted as consultants in preparing this publication.

In 1937 a handbook, "Suggestions for

Statistical Reporting and Cost Computation in Public Health Nursing," made its appearance, a compilation by a subcommittee of the Records Committee and the Service Evaluation Committee. It was distributed to all N.O.P.H.N. member agencies and to other agencies having contracts with life insurance companies, to health officers in 50 cities, and to state health departments. Work has begun on a 1943 revision.

Advice about analysis of records and a loan service of closed case records from 86 agencies are other services that the Records Committee has provided.

The Committee meets twice a year. Temporary subcommittees on current problems are appointed by the chairman. Subcommittees are composed of members of the main Committee and others. Every N.O.P.H.N. Committee is appointed for a two-year period and is dissolved in the month preceding the Biennial Convention. Serving on a committee is at times arduous, and at times amusing, even in the Records Committee.

This too is *your* committee. It welcomes suggestions for action, problems to be worked upon and criticisms of its products. Its helpfulness will depend to a great extent upon the use each member makes of it. Make it work for you!

D. E. W.

Reviews and Book Notes

LAMPS ON THE PRAIRIE

Compiled by the Writers' Program of the Works Projects Administration in the State of Kansas; sponsored by the Kansas State Nurses' Association. 292 pp. Order from the History Committee, 817 State Street, Emporia, Kansas. 1942. \$3.

The compilers of this interesting book have wisely opened it with a brief account of the development of the state. Though Coronado rode across its plains in 1541, it did not become a part of the United States until 1803 and was not admitted to statehood until 1861. Not until the close of the Civil War did it have peace to develop as a state—peace highlighted by “blizzards, droughts, floods, cholera, prairie fires, grasshoppers . . . buffalo, prairie schooners, stage coaches, cattle, railroad building, broncho busting, sod houses, pioneering, Exodusters, and oil.” Against this background the story of nursing is unfolded. There are interesting accounts of Indian medical lore and of the first settlers and the homely remedies and neighborly care administered under primitive conditions by women whose only source of medical and nursing knowledge was experience and folklore.

As elsewhere, most of the first graduate nurses (who appeared on the scene in the late 80's and early 90's) entered private practice. Nurses—or doctors either, for that matter—were usually not called until the patient was desperately ill. Especially in rural Kansas typhoid was a frequent scourge. Patients and their families in these farm homes were often ignorant of the simplest rules of hygiene and sanitation and resented and were suspicious of the new-fangled ways of the nurse who might arrive to find not one patient but two or three, the typhoid bedpan being washed at the family pump, flies everywhere, no screens, no

provision for refrigeration of foods, sometimes not even the homely privy. These early nurses did heroic work not only in caring for the sick but in teaching the families they served the elements of hygiene, sanitation, and home nursing, and in overcoming resistance to trained and scientific care. There was no division in those days between private duty and public health nursing!

In Kansas, as elsewhere, the development of public health nursing was slow until after the first World War, though the first public health nurses were employed in the early 1900's. The chapters on public health nursing, including “War, Prosperity, and Depression” are an interesting summary of the impact of those forces on the development of public health nursing in a particular region.

Because of the broad scope of the work, *Lamps on the Prairie* is not only an extraordinarily interesting account of the history of nursing in one state but a valuable piece of Americana.

HELEN W. MUNSON, R.N.
New York, N. Y.

PREVENTIVE MEDICINE IN MODERN PRACTISE

Edited under the auspices of the Committee on Public Health Relations of the New York Academy of Medicine. 851 pp. Paul B. Hoeber, New York, 1942. \$10.

This volume represents the third edition, completely rewritten, of the Outline of Preventive Medicine also published by the Academy. It is a new kind of publication in hygiene, resembling a series of monographs which bring to bear at the level of medical practice a wealth of information which has not been assembled before.

Preventive medicine is discussed in 49 chapters which are grouped around the

BOOK NOTES

sociobiological, the clinical, the environmental and the organizational aspects of the subject. Among the 50 authors, 30 are top-ranking clinicians, 15 are career workers in public health and 5 are research scientists. Katharine Faville writes an informative chapter on public health nursing, skillfully adapted for the information of the medical practitioner.

This is an excellent and up-to-date reference volume for public health nurses. The New York Academy of Medicine is to be congratulated on this volume which carries forward a high tradition of public service. Through this work the Academy has made again a real contribution toward achieving that understanding by the medical profession of public health and its methods which the public health profession so earnestly seeks, and for which it so seldom receives such splendid cooperation from the profession of medicine itself.

REGINALD M. ATWATER, M.D.
New York, N. Y.

A HANDBOOK FOR INDUSTRIAL NURSES

By Marion M. West, S.R.N., S.C.M. 134 pp. Edward Arnold & Company, London, 1941. Available through G. E. Stechert & Company, New York. 85c.

In this volume the author states it is her purpose "... to explain something of what industrial nursing is, and may become. . . ." The material is well organized and presented in an interesting manner. The writer expresses a philosophy of industrial nursing which should be an inspiration to every industrial nurse and a guide for any nurse entering this specialized field.

A brief review of the growth of industrial nursing is given. The interrelation of the early industrial and district nurses' work is described. The manner in which this interrelation has developed will interest public health nurses who are striving to coordinate services

for workers. The chapter devoted to records and records keeping offers both an excellent philosophy of record keeping and practical suggestions for types of records and reports which should be kept by every industrial nurse. A method of keeping sick absence records and determining the absence rate is described in considerable detail. The duties and responsibilities suggested by the Industrial Nurses' Subcommittee of the Public Health Section of the Royal College of Nursing are quoted, also, "Guiding Principles to Govern Routine Treatment Given by the Industrial Nurse." The latter are what we usually describe as standing orders.

The changing concepts of industrial medical practise, particularly the increased interest in health promotion and protection of workers, are reflected in the discussion in the chapter on the duties and qualifications of the industrial nurse. The preparation necessary for the nurse to function effectively in the modern industrial medical department is described as including good basic hospital training, preferably with additional experience in casualty and outpatient departments, and postgraduate preparation in public health nursing.

The author points out in the conclusion that "the traditions and precepts of industrial nursing are still being built up." Writers with the vision and understanding of Miss West will contribute much to the development of industrial nursing.

OLIVE M. WHITLOCK, R.N.
Bethesda, Md.

ANNUAL SALARIES AND SALARY INCREASES PAID TO GENERAL STAFF NURSES

Prepared by The Department of Studies, National League of Nursing Education. 50 pp. The American Nurses' Association, New York. 1943. 50c.

This 50-page pamphlet summarizes data about 26,520 general staff or gradu-

PUBLIC HEALTH NURSING

ate general duty nurses employed in 1,155 hospitals.

The median salary to nurses for whom full maintenance is provided is \$981, this group including 42 percent of the total.

Partial maintenance is provided for 45 percent—the median salary being \$1,144. In three fourths of the hospitals reporting allowances to nurses living outside the hospital, the money paid covers the cost of room only. The median room allowance provided is \$144.

The median yearly salary when no maintenance is provided is more than \$1,200. Only 14 percent of the hospitals pay less than \$1,200. Nurses in this group comprise 13 percent of the total. Nearly half are located in the Pacific states.

As a whole, general staff nurses in

government controlled hospitals receive higher salaries than do nurses in either voluntary or proprietary institutions.

Increases in salary are provided for general staff nurses in 80 percent of the hospitals. Half of the hospitals granting increases give them at the end of the first year and not again. Thirty-five percent give them at the end of the first and second years only.

The material in this pamphlet is of interest to all graduate nurses. One could wish that salary data for instructors and nurses in administrative positions in schools of nursing and hospitals could be analyzed in a similar way. The writers of the report hope that state and local consideration of the findings will follow and that individual hospitals will check their own salary practices against those of other hospitals. D. E. W.

RECENT PUBLICATIONS AND CURRENT PERIODICALS

WARTIME

TOGETHER WE SERVE: VOLUNTARY AGENCIES AND THE WAR PROGRAM. U. S. Office of Education. Education and National Defense Series, Pamphlet No. 24. Superintendent of Documents, Washington, D.C. 1942. 22 pp. 15c.

CHILDREN BEAR THE PROMISE OF A BETTER WORLD. Defense of Children Series. U. S. Children's Bureau. Superintendent of Documents, Washington, D.C. 1942. \$3 per hundred.

- No. 1. What Are We Doing to Defend Them?
2. Are We Safeguarding Those Whose Mothers Work?
3. Are They Getting the Right Start in Life?
4. Have They the Protection of Proper Food?
5. Are We Defending Their Right to Health?
6. Their Defense Is the Security They Find at Home.
7. Their Education Is Democracy's Strength.

8. Through Play They Learn What Freedom Means.
9. Our Nation Does Not Need Their Toil.
10. Are We Helping Those with Special Needs?
11. Protect Them from Harmful Community Influences.
12. Is Their Safety in Wartime Assured?

THE Y.W.C.A. AND WARTIME AGRICULTURE. Adria Titterington. Bulletin II. March 1943. 23 pp. Mimeographed. Free.

GENERAL

EXCERPTS FROM PROCEEDINGS; 33RD CONVENTION American Nurses' Association, 1790 Broadway, New York City. 1942. 173 pp. \$1. (House of Delegates Report, 35c additional.)

HOSPITAL SERVICE IN THE UNITED STATES—1943. *The Journal of the American Medical Association*, 535 North Dearborn Street, Chicago, Illinois. Reprinted from the Hospital Number, March 27, 1943. 22nd Edition. 85 pp. 75c.

A complete 1942 census of hospitals registered by the American Medical Association.

BOOK NOTES

HOW GOOD IS THE EARTH; A VENTURE IN REDISCOVERY. Courtenay Dinwiddie. Publication No. 385. National Child Labor Committee, 419 4th Avenue, New York City. 1942. 15 pp. 10c.

HOUSING

HOUSING HANDBOOK FOR SOCIAL WORKERS. Case-workers' Committee on Housing. Welfare Council of New York City. 44 East 23 Street, New York City. 1942. 18 pp. 25c.

A PROGRAM FOR HOUSING WORKERS IN WAR INDUSTRIES. Recommendations of the National Committee on the Housing Emergency, 512 Fifth Avenue, New York City. 1942. 30 pp. 10c.

Prepared to help communities meet emergency housing needs in terms of permanent planning.

SOCIAL HYGIENE

SOCIAL HYGIENE YEAR BOOK—1942: THE PROGRAM IN ACTION IN THE STATES AND COMMUNITIES. Edited by Jean B. Pinney. American Social Hygiene Association, 1790 Broadway, New York City. 1943. 252 pp. \$1.

A useful compilation of information about federal, state, and local organizations with social hygiene programs. The lists of agencies and agency personnel will be of value to all health and welfare workers, especially those who travel extensively.

FEDERAL PROBATION. Quarterly Journal. The Administrative Office, U. S. Courts, in Cooperation with the Bureau of Prisons, Department

of Justice, Washington, D.C. April-June 1943. Free.

The issue of *Federal Probation* contains a symposium of 10 articles dealing with a general survey of the problem of venereal diseases and prostitution.

THE REPRESSION OF PROSTITUTION FOR VENEREAL DISEASE CONTROL. *Baltimore Health News*, Baltimore City Health Department, Baltimore, Maryland. January 1943. Free.

THE WARTIME CONTROL OF VENEREAL DISEASE. John H. Stokes, M.D. *The Journal of the American Medical Association*, 535 N. Dearborn Street, Chicago, Illinois, December 5, 1942, p. 1093. 25c an issue.

RECOMMENDATIONS TO STATE AND LOCAL HEALTH DEPARTMENTS FOR A VENEREAL DISEASE CONTROL PROGRAM IN INDUSTRY. Advisory Committee on the Control of Venereal Diseases, 1942. *The Journal of the American Medical Association*, November 14, 1942, p. 828. In reprint form.

PUBLICITY

WRITING THE CASE STUDY. Basil Beyea. Social Work Publicity Council, 130 East 23 Street, New York City. 1942. 32 pp. 60c.

Useful to nursing agencies seeking to increase public understanding of their programs. Mr. Beyea gives illustrations of the right and wrong way to write case stories, hints for selection of material and its translation into story form.

PUBLIC HEALTH NURSES ARE ESSENTIAL WORKERS!

ALTHOUGH a great deal of emphasis has been laid on the fact that essential workers are vital to war production, there is still much work ahead in registering this fact with the public, and with the workers themselves. Occupational deferment usually indicates that a man is making a more valuable contribution to war, right now, than if he were in uniform. . . .

We realize how difficult it is for workers in civilian clothes to explain to their friends and neighbors why they are not in

the armed forces. The public should realize that the young, able-bodied man in civilian clothes may be anxious to join the armed forces. It simply happens that his work is too important to induct him at this time, or perhaps, he may have already been considered and did not measure up to the physical standards of the armed forces, even though he has a healthy outward appearance.

PAUL V. McNUTT, CHAIRMAN
WAR MANPOWER COMMISSION

NOTES FROM THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

IN THE FIELD

Washington, D.C., May 6—Hortense Hilbert attended the hearings of the Senate Committee on Education and Labor on Bill S.983, providing for federal aid for training of nurses. . . . NATIONAL ASSOCIATION OF COLORED GRADUATE NURSES, INC., New York, May 9—Miss Hilbert was the guest of the N.A.C.G.N. at their annual board meeting and represented public health nursing on a panel discussion of "How Can Nurses Work Toward Unifying the War Effort." . . . STATE-WIDE INDUSTRIAL NURSES' INSTITUTE, Lansing, Michigan, May 16—Mrs. Bethel McGrath talked at two sessions of the institute, about cooperation between national and state nursing organizations and later on problems of nurses in industry. . . . Washington, D.C., May 17—Ruth Houlton attended the first meeting of the newly formed Quota Committee of the Nursing Supply Unit of the War Manpower Commission. . . . VISITING NURSE ASSOCIATION, Elizabeth N.J., May 19—Miss Hilbert met with the Board members to discuss a study which they are conducting of their own association and of the other public health nursing services in the community. . . . BOARD MEMBERS' ORGANIZATION OF CONNECTICUT PUBLIC HEALTH NURSING ASSOCIATIONS, Hartford, May 20—Ruth Fisher spoke at the afternoon session of the Twenty-fourth Annual Meeting on "Conserving Your Nurse Power." . . . COMMUNITY HEALTH ASSOCIATION, Boston, May 24—Mrs. McGrath spent the day in observation of nursing services in industry and consultation. . . . WAR CONFERENCE OF THE AMERICAN ASSOCIATION OF INDUSTRIAL PHYSICIANS AND SURGEONS, THE AMER-

ICAN INDUSTRIAL HYGIENE ASSOCIATION, AND THE NATIONAL CONFERENCE OF GOVERNMENTAL INDUSTRIAL HYGIENISTS, Rochester, New York, May 24-27—Attended by Mrs. McGrath, May 25 and 26. . . . CENTRAL BERGEN VISITING NURSE SERVICE, INC., Hackensack, N.J., May 27—Mrs. McGrath spoke at their annual meeting about how the public health nursing association can serve industry. . . . NEW JERSEY S.O.P.H.N.—In Newark, N.J., on May 28, Miss Fisher conferred with the president of the S.O.P.H.N., the chairman and the new members of the lay section.

NEW S.O.P.H.N. HANDBOOK

The first state handbook to be issued by an S.O.P.H.N. for volunteers and board members has just been published by the Lay Section of the New Jersey organization. In looseleaf form, so that pages can be added or removed, it includes lists of national and state nursing associations; agencies having health, medical or nursing programs; information about the N.O.P.H.N. and S.O.P.H.N.; state vital statistics and recommended reading for lay people. Copies may be secured from Mrs. Walter G. Farr or Mrs. Mona Cutler Hall, S.O.P.H.N., 17 Academy Street, Newark, N. J. 25 cents.

FOLDERS ON POLIOMYELITIS

JONAS announces that folders on poliomyelitis are now available for loan. The folders include up-to-date information on epidemiology, treatment and nursing care of poliomyelitis, reprints, routines of care, and a bibliography. These folders may be borrowed for two

N.O.P.H.N. NOTES

weeks without charge except for return transportation by writing to the Joint Orthopedic Nursing Advisory Service, 1790 Broadway, New York, N. Y.

JONAS GIFT TO CHINA

The three JONAS handbooks, *Posture and Nursing*, *Orthopedic Conditions at Birth* by Jessie L. Stevenson and *Orthopedic Nursing* by Carmelita Calderwood, are being microfilmed with other text books to be sent as gifts to the Association of Nurses in China. The selections were made by the Nursing Committee of the American Bureau for Medical Aid to China.

HONOR ROLL

Nursing agencies with all members of their full-time regular nursing staff enrolled in the N.O.P.H.N. for 1943 are eligible to receive an Honor Roll Certificate and to have the agency name appear on this list. Any agency may qualify regardless of size—whether it has one nurse or many.

If your agency is eligible for the Honor Roll and you have not notified N.O.P.H.N., send us a postcard so that the name of your agency will be on the next list.

We are happy to add to our Honor Roll the following agencies in which 100 percent enrollment has been achieved since our last list was published.

ARIZONA

Cottonwood—Marcus Lawrence Clinic

CALIFORNIA

- *San Francisco—California Tuberculosis Association
- *San Jose—American Red Cross Chapter, Visiting Nursing Service
- Woodland—Yolo County Health Department

*Agencies which have been on the Honor Roll for five years or more.

COLORADO

- Lamar—Prowers County Nursing Service
- *Las Animas—Bent County Public Health Nursing Service
- *Pueblo—School District No. 20
- *Pueblo—Metropolitan Life Insurance Nursing Service

CONNECTICUT

- Easton—Public Health Nursing Association
- *Fairfield—Visiting Nurse Association
- *Greenwich—Town Nursing Service
- *Portland—District Nurse and Welfare Association

IDAHO

- Boise—Idaho State Department of Public Welfare, Division of Public Health Nursing

ILLINOIS

- *Alton—Metropolitan Life Insurance Nursing Service
- *Bellwood—Board of Education—District No. 88
- Charleston—Public Schools
- *Evanston—Visiting Nurse Association
- Gillespie—Metropolitan Life Insurance Nursing Service
- *Granite City—Metropolitan Life Insurance Nursing Service

INDIANA

- Bedford—Lawrence County Nursing Service
- *Indianapolis—Public Health Nursing Association

IOWA

- *Dubuque—Health Department—Division of School Nursing
- *Waterloo—Visiting Nursing Association

KANSAS

- Eureka—Board of Education
- Topeka—Metropolitan Life Insurance Nursing Service
- *Wichita—Public Health Nursing Association

KENTUCKY

- *Hopkinsville—Metropolitan Life Insurance Nursing Service

LOUISIANA

- East Baton Rouge—Parish Health Unit

MARYLAND

- Belair—The Harford County Health Office

MASSACHUSETTS

- Chicopee—Community Nursing Association
- *Hanover—Visiting Nurse Association, Inc.
- *Quincy—Visiting Nurse Association, Inc.
- Sudbury—Public Health Nursing Association

MICHIGAN

- *Detroit—Visiting Nurse Association

PUBLIC HEALTH NURSING

Detroit—Wayne County Superintendent of Schools
 *Lansing—Greater Lansing Visiting Nurse Association
 Ludington—Mason County Health Department

MINNESOTA

*Minneapolis—Community Health Service
 *St. Paul—Family Nursing Service

NEW JERSEY

*Montclair—Bureau of Public Health Nursing
 *Orange—Visiting Nurse Association of the Oranges and Maplewood
 *Trenton—Visiting Nurse Association

NEW YORK

*Batavia—Metropolitan Life Insurance Nursing Service
 Belmont—Allegany County Public Health Nursing Service
 Brooklyn—East New York Office of Brooklyn Visiting Nurse Association
 Mohawk—Herkimer County Public Health Nursing Service
 Poughkeepsie—Visiting Nurse Association

OHIO

Ashtabula—City Schools

OKLAHOMA

Ardmore—City-County Health Department
 Pawhuska—Osage Indian Clinic
 Tulsa—Cooperative Clinic

OREGON

Klamath Falls—Klamath County Health Department
 *Vale—Malheur County Public Health Association

PENNSYLVANIA

Kingston—West Side Visiting Nurse Association
 *Lewisburg—Community Nurse Association

RHODE ISLAND

*Cranston—District Nursing Association
 *Newport—Newport Hospital School for Nurses
 *Saylesville—Sayles Finishing Plants, Inc.

SOUTH CAROLINA

*Edgefield—County Health Department

TENNESSEE

*Chattanooga—Metropolitan Life Insurance Nursing Service

UTAH

*Salt Lake City—Visiting Nurse Association

VIRGINIA

Arington—Bureau of Nursing Service

WASHINGTON

*Spokane—Metropolitan Life Insurance Nursing Service

WISCONSIN

Hammond—St. Croix County Nurse

WYOMING

Riverton—Fremont County Public Health Nursing Service

SECTION HOLDS MEETING

A special meeting of eastern members of the Executive Committee of the Board and Committee Members Section was held at N.O.P.H.N. headquarters May 21 when Mrs. Sumner Spaulding, member from Beverly Hills, California, made an unexpected trip to New York. Discussion of how the Section can cooperate with the School Nursing Section in interpreting the essential wartime functions of a school nurse was a highlight of the meeting. Every board and committee member in the country will be asked to help with this interpretation and the development of volunteer programs in schools. Plans were also made for seeking the help of national women's organizations in organizing citizen committees in the 16 communities recently surveyed by the N.O.P.H.N. These communities had no organized resource for public health nursing.

A guide to the promotion of pay service, prepared by the Section, is now ready for distribution. Copies may be secured from the N.O.P.H.N. at a cost of 25 cents each.

Members of the Section who have been appointed state lay membership representatives since the previous announcement in the April magazine are: Mrs. Clifford Lamar, Birmingham, Alabama; J. G. Griswold of Fordyce, Arkansas; Mrs. Sumner Spaulding, Beverly Hills, California; Mrs. J. Randolph, Savannah, Georgia; Mrs. R. S. Stringfellow, Boise, Idaho; Mrs. Lois Spruill, Estancia, New Mexico; Mrs. H. Edward Bilkey, New York City for the metropolitan area of New York; Mrs. Tom Sprinkle, High Point, North Carolina; Mrs. E. Jeanette Morse, Sugarloaf, Pennsylvania; Mrs. Arch Trawick, Nashville, Tennessee; Elizabeth Wolfe, Parkersburg, West Virginia; and Mrs. R. H. Williams, Juneau, Alaska.

NEWS

Highlights on Wartime Nursing

PROGRESS ON THE STUDENT RESERVE BILL

Hearings on the bill to provide further federal aid for student nurse training were held before a House Committee on May 6 and a Senate Committee on May 6-7. Nursing authorities and other interested persons from all parts of the country presented facts concerning the shortage of nurses which now exists and the need for federal aid to stimulate recruitment and training. Since many amendments were suggested, a new bill (H.R. 2664) covering these points was written and introduced in the House May 10 by Mrs. Chester Bolton. It was passed May 14. The same bill was introduced in the Senate May 17, and reported favorably out of Committee with one amendment. This is the status of the bill as of the last week in May. The bill must now be voted on by the Senate, and returned to the House for reconsideration with the amendment.

Incidentally, the N.N.C.W.S. special committee reported in April **PUBLIC HEALTH NURSING** (p. 233) was formed to prepare for hearings on the student reserve bill, not for possible hearings on a proposed nursing supply and distribution unit as stated.

• Fifty volunteers recently completed a 14-weeks' training course at the Shorewood, Wisconsin, Health Department and are now working as "health assist-

ants." Irene H. Hugunin, supervisor of public health nurses, writes, "The health assistants . . . are helping us maintain our health standards in spite of personnel changes and greatly increased load of work. They are rendering their community a real service and we are proud of them. I feel every community should prepare themselves in this or some similar way for the emergency that is bound to come."

• After establishing emergency classifications in its merit system in order to fill wartime vacancies among health personnel, the State Board of Health in North Carolina last January started an orientation training course for public health workers including 14 nurses. The course consisted of a two-week period of classroom discussion followed by field work in selected local health departments. Nurses who completed the course were called "junior public health nurses" and assigned to local health departments, usually in their own communities.

• Lack of applicants for public health nursing positions despite plenty of available funds, need to continue staff education programs by state consultants for the duration, need for strong supply and distribution committees in the states, the trend toward bedside care service in official agencies—these were subjects under discussion at the Conference of State Directors of Public Health Nursing, District 3 of the U. S. Public Health

PUBLIC HEALTH NURSING

Service, Chicago, April 26 to 28. Representatives from six states attended, also Pearl McIver, principal nursing consultant of the Public Health Service and Ruth Heintzelman of the Children's Bureau. The requirement that nurses buy their own cars was agreed to be a leading difficulty in obtaining personnel. It was suggested that private agencies buy cars and make them available to public health nurses under the same arrangements for upkeep that are made when cars belong to nurses.

- A preliminary tabulation of reports from 30 states in the 1943 Inventory of Registered Nurses indicates that the dis-

tribution of nurses among the major types of nursing work, namely, public health, institutional, private duty and industrial has changed only slightly. In 1941, 10 percent of all nurses were engaged in public health work, while in 1943, 11 percent of the nurses in these 30 states were in public health. In 1941, 47 percent of all nurses were in institutional work; in 1943, 44 percent. The percentage in private duty is practically the same as in 1941, but the percentage in industrial nursing has increased from three to seven percent. A total of 179,999 cards, about 71 percent of the cards mailed, had been returned to the Public Health Service by April 21.

From Far and Near

- The U. S. Civil Service Commission announces unassembled examination No. 250 for the following positions: senior nursing education consultant, \$4,600; nursing education consultant, \$3,800; associate nursing education consultant, \$3,200; assistant nursing education consultant, \$2,600. Announcement is also made of unassembled examination No. 269 for the position of graduate nurse at \$1,800 a year.

Applications for the above, which must be filed with the U. S. Civil Service Commission, will be accepted until the needs of the service have been met. Forms may be obtained from the Commission, Washington, D. C. and title of examination desired should be stated.

- In recognition of her contribution to the general health and welfare of Hawaii, Jane Service, chief public health nurse for the Island, has been presented with a life membership in the National Organ-

ization for Public Health Nursing. A gift from friends and coworkers, the presentation took place at the annual Territorial Nurses' meeting, April 21. Mary Williams, director of the Bureau of Public Health Nursing, writes of Miss Service, "She is a strong, dynamic personality and you would love her sense of humor! She has done much to uphold nursing standards, as well as taken active part in Hawaii affairs, both local and territorial."

- The following are the newly elected officers of the Rhode Island State Organization for Public Health Nursing for 1943:

President—Mrs. Mildred Hatton, Providence
Vice-President — Theda Waterman, Woonsocket

Treasurer—Florence Tanner, Providence
Secretary—Catherine Sullivan, Providence.

- The N.O.P.H.N. now has on hand a limited supply of "A Handbook on Child

NEWS NOTES

Care," published by the former East Harlem Nursing and Health Service. This valuable little handbook can be secured from our office at its usual price of 50 cents per individual copy.

Office of Community War Services—Under a recent Executive order the Office of Defense Health and Welfare Services at Washington will be replaced by the Office of Community War Services, which will function as an integral part of the Federal Security Agency. Charles P. Taft, who has been director of the Services since their inception, will become Director of Community War Services under Security Administrator Paul V. McNutt.

Emergency Medical Service for Industrial Plants—Casualty stations in alternative sites both in and outside of industrial plants, ambulance service, hospitalization of the seriously injured and adequate identifying records are recommended as essentials of disaster operations plans in a new bulletin, "Emergency Medical Service for Industrial Plants," available from the Medical Division, Office of Civilian Defense, Washington, D. C., or from state and local defense councils.

Dieticians' Aide Corps—In response to demands from hospitals a new volunteer group to be known as the Red Cross Volunteer Dieticians' Aide Corps is being organized by the American Red Cross Volunteer Special Services in cooperation with the American Dietetic Association and Red Cross Nutrition Service. The training course for this new corps will include 20 hours of standard nutrition studies, 25 hours of special training and 15 hours of practical hospital work all under the supervision of graduate dieticians. Aides who complete the course will help prepare and check diets and menus, serve food to patients and hospital personnel, and do clerical work.

Advice to Families Receiving Dependency Checks—Because many service dependency allotment checks are being stolen from porches and mail boxes and then forged, the U. S. Secret Service is urging that families make sure some member stays home when checks are due, equip all mail boxes with a lock and nameplate, cash checks in the same place each month and re-

frain from endorsing checks until in the presence of the person who will cash them.

War Nursing Literature—The early months of 1943 have produced two fine books on war-time nursing, both by nurses, both published by the J. B. Lippincott Company, Philadelphia, Pennsylvania. *Nurses in Action* by Julia O. Flikke, Colonel, AUS—Superintendent, Army Nurse Corps—is in the main the story of the Army Nurse Corps, although chapters on other government services are included. Colonel Flikke says her purpose in writing this was "to offer to young women everywhere information about one of the most important, romantic, and soul-satisfying professions open to women." This volume is a boon to those concerned with recruitment programs and an inspiration to all members of the profession. The second book is autobiographical and deals directly with the experiences of one of Colonel Flikke's "nurses in action" in this War. *I Served on Bataan* by Juanita Redmond tells in vivid detail of a member of the Army Nurse Corps from the time of prewar nursing in the Philippines through Pearl Harbor, Bataan, Corregidor, and Australia.

Nutrition and Public Health—Poor food habits including over-indulgence in candy, soda and alcohol and undeveloped tastes for protective foods; too much vitamin-free or poor caloric food such as highly-milled flour and refined sugar; price rationing with only half our population able to buy as much as three fourths of what they need for a nutritionally satisfactory diet; neglect to prevent and correct malnutrition during and after illness—these are the major causes of poor nutrition in the United States according to Dr. Norman Jolliffe. After discussing these four points, Dr. Jolliffe indicates for infants, children, adolescents and adults early signs of nutrition depression to be watched for:

"Laymen should be taught that in infants and children these early symptoms include lack of appetite; failure to eat an adequate breakfast; failure to gain weight steadily; delay in learning to sit, stand, or walk; inability to sit or pain on sitting and standing; aversion to normal play; chronic diarrhea; poor sleeping habits; backwardness in school, and frequent colds. The following physical signs may also be emphasized to lay groups as suggestive of early nutritional deficiency states in children: Lack of subskin fat, paleness, hemorrhage of the newborn, and

(Continued on page A9)

The Newer Concepts of Meat in Nutrition

Pork ... and its advantages in WARTIME MEALS

FOR the remainder of the war period, a goodly portion of the civilian meat supply will have to be pork. What does pork offer? Does it present advantages for wartime meals?

In the uncooked state pork muscle meat contains approximately 16% protein (against an average of 18% in other meats), 35% fat (almost twice as much as the average in other meats), and 42% water (from one-fourth to one-fifth less than other meats).

The protein of pork is of high biologic value, and its fat is rich in the unsaturated fatty acids, by many investigators considered essential to human nutrition.

Its mineral content makes pork a good source of iron, copper, and phosphorus.

Pork leads all meats in thiamine content. It also contributes nutritionally important amounts of riboflavin and niacin.

While the digestive process of pork is somewhat slowed down, due to its high fat content, its coefficient of digestion is high—from 96% to 98%.

Under wartime curtailments pork is advantageous because of its high contribution to energy requirements as well as to those of many essential nutrients.

Like all meats, it stimulates the appetite, thus increasing consumption of other foods, and the prolonged postcibal satisfaction it produces is doubly valuable when food availability is lessened, as under wartime rationing.

ESSENTIAL NUTRIENTS IN PORK*

	PROTEIN	FAT	VIT. A I. U.	VIT. D I. U.	VIT. C ASCORBIC ACID MG.	THIA- MINE MG.	RIBO- FLAVIN MG.	NIACIN MG.
MUSCLE MEAT	16%	35%				1.5	0.24	8.0
HEART	17.1%	4.8%			4.0	0.6	0.12	6.5
KIDNEY	15.5%	4.6%			14.0	0.5	1.96	10.0
BRAIN	11.7%	9.0%			18.0			
TONGUE	16.8%	15.6%						
LIVER	21.3%	4.8%	9,850	44.5	24.0	0.5	2.70	19.0

*Average values per 100 Gm. fresh substance
Values based on *Waismann and Elvehjem "The Vitamin Content of Meat"*



The Seal of Acceptance denotes that the statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

American Meat Institute
CHICAGO

PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

We Who Are Supervisors

CERTAIN facts about supervisors revealed through the 1942 census of public health nurses made by the United States Public Health Service draw attention to the present-day status of public health nursing supervision. The census showed that 2,112, or one tenth of the 21,123 public health nurses of the country, were functioning as supervisors. Of these two thirds were in governmental and one third in private agencies, the ratio of supervisors to staff nurses being about 1 to 10 in the former and 1 to 7 in the latter type of agency. Thirty-two percent were college graduates and 60 percent had completed a year or more of study in public health nursing.

No soundings were taken regarding the number who had had advanced professional preparation for supervision but it is probable that the proportion was low. While several universities offering a program of study in public health nursing offer a single course in principles or methods of supervision, only four offer a major professional program with advanced supporting courses in general and nursing education, human behavior and guidance, administrative management and analytical methods.

The majority of new supervisors still learn supervision on the job, sometimes fortunate in having some introduction or guidance but more often floundering by trial and error until their success or failure is demonstrated. Too often still supervision consists solely of the management aspects. Too often the super-

visor concentrates on teaching subject matter and gives little attention to finding out what each individual nurse can bring as her unique contribution to the development of the service. Frequently still emphasis is on techniques rather than basic principles. Good nurses after reaching a plateau of accomplishment remain there because the supervisor devotes most of her time to less able nurses. Too much of the supervisor's time may be spent on the details of the program for undergraduate student nurses when experienced staff nurses could share in it with profit to all concerned. Too often the intent and method of in-service education are determined so far ahead and are so stereotyped that they are neither dynamic nor pertinent to changing situations and changing needs.

But there is a brighter side to the picture. A country-wide job analysis of supervisors is to be undertaken this year as a basis for planning better programs of study in supervision. More agencies are working on provisions for a well supervised field experience for prospective supervisors. Much attention is being given to encouraging supervisors to individualize the assets and needs of those receiving supervision. That they have gained objectivity in their relations with this group is revealed in their reports which contain noticeably less comment on the nurse's routine techniques and more about her ability in developing family responsibility, and her growth in community and professional leadership. Un-

PUBLIC HEALTH NURSING

counted numbers of capable staff nurses now are contributing to the guidance of students and are participating in policy-making for community and agency health work.

Perhaps this professional maturing could be aided and hastened by a more systematic and frequent exchange of ideas and methods. This issue of PUBLIC HEALTH NURSING serves as a me-

dium for some of this exchange. Preparation for supervision, administrative management, work planning, public health nursing participation in basic nursing education are all parts of the important job of public health nursing supervisors. We hope the articles on these subjects will provoke thought and discussion which will result in the stimulation of ideas for the benefit of all.

Nursing Education at Chicago

ONE PUBLIC health nurse who attended the annual convention of the National League of Nursing Education in Chicago, June 15 to 17, came away with the wish that many more public health nurses, especially those who are administrators, supervisors or teachers, might be taking a greater responsibility for basic nursing education than they now are. They have much to learn but they also have much to give.

Practically all discussion during the League meetings centered around the basic course. On the two days following, the Association of Collegiate Schools of Nursing met to discuss preparation and activities of nursing school teaching personnel. Many more faculty members directly affected might well have been interested in taking part in the meetings. Everyone seemed in agreement that the quantity and quality of nursing faculty—from head nurse to director—is the crucial issue during this emergency when so much public and personal money will be spent in educating so large a number of nurses. A new awareness seemed apparent that it is not so much the number of weeks spent in each service or the number of affiliations covered that counts toward successful learning, as it is that the student nurse have her every experience under the guidance of a progressive and

well-qualified teacher. We need many more of this kind.

Like general colleges, nursing schools were urged to liberalize entrance requirements and individualize acceleration for outstanding or experienced students. If state nurse practice laws prohibit such students from registration the profession must work together to remove the obstacles. The law is for the protection of users of service. Clearly they are the ones to benefit from superior service by superior nurses!

That the need was recognized for sound personnel practices for nurses, to improve morale during this universally trying period, was encouraging, but one wonders if this discussion would have been even more encouraging if the emphasis had been on working *with* the student, head nurse and supervisor in improving such practices instead of *for* them. This cooperative spirit is also necessary to best relationships with the lay persons who are now being invited to give greater assistance to nursing education through League membership.

Every public health nurse should support the director of the nursing school in her own community or vicinity, with whom she should be in close touch. One could not help being thoroughly impressed with

(Continued on page 410)

Wartime Public Health Nursing Responsibilities

By MARY ALYCE ROONEY, R.N.

HARRY L. HOPKINS in his much discussed article appearing in the December 1942 *American Magazine* makes this statement: "The vast majority of American people want laws that will concentrate our manpower on three vital efforts—to send men to war, to supply them, and to maintain the families at home." So anxious are the American people to do this that they have already and willingly put into the hands of government the authority to take long steps toward that end.

With this in mind, I know that public health nurses individually and collectively are groping for an understanding of their place in a regimented manpower nation that is concerned with winning the war in the shortest time possible and getting to the task of winning a permanent peace. None of us knows just what his place may be, but surely the public health nurse figures in all three categories referred to by Mr. Hopkins. I feel that in these days before a government-controlled system of manpower distribution, we should take stock of our capabilities and our responsibilities so that we may approach this problem better informed and hence in a more orderly fashion.

In this discussion we will confine our thinking to the public health nursing group which after all is a very small portion of the total nursing resources of the country. If we were to consider only graduate nurses as those making up our nurse power, we would, according to the

National Inventory conducted in 1941,¹ have approximately 9.5 percent of the active nurses in the United States in public health. However, we know that graduate nurses do not make up the total nurse power. Auxiliary nurses, nurse's aides, orderlies, and others add to the numbers of graduate nurses, and altogether they make up a sizable pool of nursing power. Because of the nature of our duties in the public health field, we have not in the past used the auxiliary nurse to any great extent, and so we may safely say that of the total nursing resources less than 9.5 percent are in the public health field.

For various reasons we have seemingly classified nurses into two groups, those under 40 and those over 40—one might say the group that hasn't lived and the group that has begun to live. According to the National Inventory 58 percent of the public health nurse-power is under 40 while 77 percent of the total graduate nurse-power is under 40. In other words, in public health we have fewer nurses both relatively and in numbers who are under 40.

RETURNING again to Harry Hopkins' definition of vital efforts—to send men to war, to supply them, and to maintain the families at home—nurses, I believe, have come so far in their thinking as to agree with Mr. Hopkins and are resolved that everything in their program should be geared to the total war effort. Let us

now consider the first of these vital efforts, to send men to the military service, and see how public health fits into the picture. Selective Service has focused considerable attention on physical fitness. I believe that the complete physical examination given at induction centers has gone farther in teaching the general public about the essentials and value of periodic check-ups and correction of defects than anything we have done in our health programs. Furthermore, this teaching has been real. On every hand we have people, especially men and boys, seeking information on ways and means of improving and maintaining general health. Important sources of this information are the health department and the public health nurse.

In a recent visit to a "career day" program in a high school I was greatly interested to see how the average high school boy has accepted the fact that he is already in pretraining for the military. Most of the boys were interested in the Air Corps, the Navy, the Marines, and other branches of service where there is a great deal of action and also where a high degree of physical fitness is a prerequisite. There were counsellors at this meeting who talked with individuals and groups interested in particular training. The counsellors for the military forces stressed the need for physical health, and in all instances these boys had direct questions that pertained to health. The schools represented in the group were not served by a health department nor public health nurses, and I fear that some of these young boys may not find qualified people to answer their questions. I hope the same situation does not exist in areas served by health departments and public health nurses. Typical questions of these young people within or about to be included in Selective Service groups are:

What are the so-called protective foods and just what will they do for me? If I eat a lot of carrots will my eyesight be better? What corrections are possible to remedy physical defects? What does my draft board mean when they say "rejected because of a positive blood test, because of chest involvement," and what can I do about these conditions? Do these conditions have a direct bearing upon my future health? May I expect further damage unless the conditions are corrected?

No longer is it possible to say to the questioners, "See your family physician." The family physician is probably over in El Alamein removing shrapnel from the body of one of our heroes. Nurses must be prepared to answer these questions and, furthermore, they must be prepared to help others who might also answer these questions. At this time the public health nurse should become an information resource to the teacher, the draft board, the social worker and the hosts of others upon whom we shall depend for help in conveying the health message.

WHILE it may appear that I have stressed preparing the man for the military, I wish also to point out our real obligation to the man who has been rejected as non-fit. As older men come up for induction there will be a proportionately higher percentage of rejections, and we should be on hand to help these men to prepare for a civilian role in the war effort and also help them to secure correction of their defects and adjustment to conditions where further damage is prevented. A cousin of mine serving on a draft board told me that their most harassing problem was dealing with the rejectee who did not fully accept his rejection, particularly when the rejection was because of a physical defect. The rejectee when asked why he wasn't in the

army, very often couldn't bring himself to say, "I was rejected because my eyesight or hearing wasn't quite good enough." Or, "The board thought that my general physical condition was not such as to withstand the rigors of military life." But rather he would say, "It's all in knowing how to talk to the boys on the draft board." Such remarks foster a real feeling of resentment and greatly disrupt our civilian morale. Being unsuited for military service is no reflection whatsoever on those not accepted in the draft, and nurses should help to interpret this concept. This is a real task. It has deep implications in our work with families and individuals alike, and unless it is carefully dealt with it can be a very damaging experience to the rejectee and the community alike. Surgeon General Parran recently said, "... if it is stupid to waste money and material ... it is treasonable to waste manpower."² Manpower is certainly wasted when men do not function to the best of their possible physical strength, either in the military or civilian war effort.

THE second vital effort referred to by Mr. Hopkins is to supply the men sent to the military. That means to keep on the job the men and the women who supply the Army. Few states are doing quite so much as we are in Michigan. We are producing and making much of the ammunition and the equipment that carry the war to the enemy. Equally important is our agricultural production—fruits, vegetables, dairy products. We know that before another harvest, we will scrape the barrel for available labor to produce that crop. We know that many of these new laborers will be women who will bring with them special problems that involve not only themselves but their children as well. We already have in the United States over 14 million women employed,

and government estimates say that during 1943 war industries will employ approximately 5 to 6 million additional women workers. Mr. McNutt in September said, "Increased participation of women in our all-out war production effort is essential to its success. War production alone employed about 1,400,000 women last December. This figure will jump to 4,500,000 by December 1942 and will climb to 6,000,000 by the end of 1943. By then, women will represent at least 30 percent of the labor force employed in war production."³

The Census Bureau points out that we simply cannot get the additional women workers without making heavy inroads upon mothers since the chief reservoir of labor supply is among women 18 to 44 years old. With this reservoir already deeply tapped many of the new workers will of necessity be the mothers of young children. All the elements of utter tragedy are in the making here. We know that children separated from home ties and without competent care during the impressionable age are troublemakers—the neurotics, the spiritual and emotional cripples of a generation hence. Yes, and it is this generation which must rebuild, preserve, and defend the United States of tomorrow. This problem of child care is a real one. The Federal Government is taking some steps to deal with this problem through the Children's Bureau and the War Manpower Commission. Michigan is dealing with it in a similar manner. An experienced social worker has been appointed chief of the Division of Health and Welfare in the Michigan Council of Defense, and one of his duties will be to study this problem and take steps to alleviate some of its dangers. He has spoken so often of the need for counseling these mothers in their home environment, and he has paid special tribute to the nurses' skill in doing this. Some

PUBLIC HEALTH NURSING

mothers should not leave their homes, some should provide better care for their children, and all can and will profit if given an opportunity to discuss plans and problems with a public health nurse. We say glibly, "Tomorrow is for our children." To preserve tomorrow and not the children is utterly illogical.

NURSES in rural areas as well as in industrial areas will be needed to help rehabilitate certain individuals, to speed the recovery of those who are sick, and to help maintain the health of the employed. Through these efforts they will help materially to supply the men sent to the military. The rehabilitation of the worker may include finding light work for the ex-tuberculosis patient, the cardiac patient, or the person who has suffered injury. Nurses may need to interpret the worker's limitations, both to the employer and to the employee.

We may all expect to lend our assistance to speeding the recovery of those ill. An idle machine, a noncultivated field, or unpicked fruit are all real examples of national sabotage and examples of gross sabotage if the worker is ill because of a preventable disease or one where recovery could be hastened. An important factor to speedy recovery is nursing care. Basic to a nurse's preparation for public health is knowledge of how to take care of the sick and how to interpret this to others. Health departments and public health nurses have a growing responsibility in home care of the sick during the emergency. The need is increasing because of crowded conditions in hospitals which are necessitating the restriction of admittance to the critically ill only, and early dismissal of those patients in the early convalescent period. Home care of the sick can no longer be treated as a separate health service but must be incorporated

into the total program. To give this service, adjustments must be made in existing programs. Even with adjustments few health departments can expect to give bedside care on anything but a demonstrational basis, but such a service should go far in helping to supply essential nursing care for the sick of our communities. To facilitate this type of a program the public health nurse may:

1. Inform local physicians that she is available to demonstrate care in those homes where there are acutely or chronically ill patients not receiving adequate care.
2. Enlist the help of women in the community who have taken the home nursing course to act as neighbor nurses in giving care to the sick.
3. Maintain a roster of women who can give home care to the sick on a volunteer or pay basis. The type of care given may be improved through occasional supervisory visits.

Another adjunct to the home nursing care of the sick is through extension of home nursing classes. The national quota set by the Office of Civilian Defense and the American Red Cross is to have one person in each family trained in home nursing. To accomplish this the public health nurse must give her assistance, and we believe it can best be given if she will:

1. Assist in recruitment of instructors.
2. Help instructors in their class preparation and teaching.
3. Teach selected groups when other instructors are not available, as in strictly rural areas. When public health nurses have not taught nursing within the last two years, it is recommended that they teach at least one class so that they may be better able to help other instructors and may be able to make a selection of women who can act in the capacity of "neighbor nurse."

OUR responsibility for helping to maintain the health of the worker is closely identified with the third vital effort as defined by Mr. Hopkins, "to maintain the families at home." Public health nurses who are trained as community and family

WARTIME RESPONSIBILITY

workers have, I believe, a unique contribution to make in this effort. Family and community health, both mental and physical, receive during wartime terrific shocks that if not properly adjusted leave scars to cloud the days of our peaceful years that lie ahead.

Only to mention a few community problems that have their implications in public health: In crowded industrial areas throughout the country we have people living in trailers, tents, overflowing rooming houses, and shacks where sanitary arrangements are inadequate. Stores and cafes are jammed, rents are skyrocketing, and food is poor and expensive. Springing up in increasing numbers are cheap and undesirable forms of recreation—shooting galleries, travelling carnivals, houses of prostitution. The public health problems attending these conditions are terrific to say the least. Diphtheria, smallpox, and typhoid have put in their appearance; tuberculosis, syphilis, and gonorrhea are increasing. We cannot rest on the laurels of our past. Population is shifting rapidly. Yesterday's well-informed and protected population may be out in Kaiser's shipyards today, and those who were cotton pickers last year may be working on assembly lines in Michigan.

I like to think of the public health nurse as the quiet worker who goes about her tasks building morale. Virginia Jones and Mildred Byers,⁴ speaking of the contribution of the public health nurse during wartime, say: "Above all, the reassurance of their presence doing the familiar things, their sustained interest in the universal problems of mothers with children, their calm presence in the maternal and child health conferences, . . . their understanding in the face of fear, insecurity, and racial prejudices—these were and are their special contributions."

Our men are fighting to preserve "our

way of life." Always they say, "Take care of things at home." They expect the home front to be preserved. They are fighting for that very thing. Public health, as the name implies, is a thoroughly democratic function and part "of our way of life." It must be maintained if we are to "take care of things at home."

THE duties of the public health nurse are many and varied. We properly question at this time how many are essential to the war effort. All of us are asking the same question and in many places attempts have been made to define what are essentials of community service. The Bureau of Public Health Nursing with the help of directors of other bureaus of the Michigan State Department of Health attempted this by defining priorities of service and suggesting adjustments in the programs so that more public health nursing time could be devoted to the pressing problems of the present. These recommendations merit thinking and study. In New York State selected public health nurses have been asked to keep a month's tabulation of their activities by 30-minute intervals and beside each performed task indicate if what they did could have been done by a lay worker, paid or volunteer, and if there was any duplication of service either by their agency or another. We have long recognized that many of our tasks could be done by the lay worker. Now we must prepare to delegate more to that worker—remembering, however, that responsibility accompanies the delegation of duties. Much has been said about duplication of services, and overlapping of services. In some areas the situation has been the object of discussion only. Now we need action, not only discussion. In one area in Michigan of approximately 60,000 population that I visited last sum-

PUBLIC HEALTH NURSING

mer there were nine agencies employing public health nurses. In such a place there cannot help but be overlapping, duplication, wasted public health nurse-power. There are other examples of duplication, particularly in the selection of families carried for service. This is surely the time to give strict attention to case selection. Can we not expect certain families to take more responsibility now than in the past for their health protection? Are there ways in which we can test our teaching to see if our families are really benefiting? Do we consider the opportunities that the family has for receiving health service or instruction from other sources? What is the individual's educational background, capacity to learn, and willingness to accept teaching? Let us consider all these factors and when they become a functioning part of our case selection mechanics, I feel sure that we can truly define essential services of the public health nurse.

YES, our programs and our services need adjustments. There is the large field in public health that the war emergency has opened up—"to send men to war, to supply them, and to maintain the families at home." Public health nurses, I believe, are among the ones best prepared to carry out the health functions in these efforts. But if we are to make a lasting impression, we must have the personnel to do it, and it is to that point I wish to confine my last remarks. To maintain a staff of workers a supply must be constantly coming to us. Our source of supply, the

young energetic nurse who will take time out to prepare herself for public health, is no longer available. She is joining the military and rightly so. In nurses of the age group that have not yet begun to live, there is that patriotic drive to be doing the thing that calls for action and immediate sacrifice. Like the high school boys, we want to be "in and at it," and little that I or anyone can say will change that feeling within nurses who are by nature patriotic and adventurous. So to do this task, we must rely very largely upon our present force. By training and experience the public health nurses are especially fitted to the task of influencing people's behavior toward positive health, especially that of the men and women upon whom we shall depend to enter the military forces and produce the goods to supply the military. The home front must be maintained, and it will only be maintained if people like public health nurses who are versatile in making adjustments and doing tasks under adverse conditions remain on duty and carry the democratic torch of public health. Furthermore, the tasks of the reconstruction period will be tremendous and public health nurses will be urgently needed, both because of their particular training and experience and because they will be living examples of our democratic way of life. Public health nurses are essentially rebuilders and the reconstruction period will challenge us all.

Presented at the Michigan Public Health Association meeting, Grand Rapids, Michigan, November 12, 1942.

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Educational Opportunities for Industrial Nurses

By CATHERINE E. DENNING, R.N.

LEARNING by doing is the method which up to now has mainly constituted the specialized training of the nurse in industry. Many nurses engaged in or contemplating industrial nursing careers have had neither experience nor special theoretical preparation for this field.

Today, some universities are realizing the need for courses for nurses in industry. Sabbatical leaves, scholarships and traveling expenses for educational purposes are not yet the pattern for the industrial nurse. As a result, if special preparation is to reach her, special plans seem to be necessary. In Ohio this has been done in a number of ways.

PROFESSIONAL ORGANIZATION

Interesting industrial nurses in education is not an easy task unless they have a common interest. As a first step, it was considered necessary by industrial nursing leaders in the state to help organize industrial nurses into officially recognized groups. At the annual meeting of the Ohio State Nurses' Association in May 1942 an industrial nursing section was created. The new section was called the "Industrial Nursing Section of the Ohio State Nurses' Association," a title chosen deliberately to denote a professional rather than a social organization.

Following this action, the various district associations helped industrial nurses to organize. Today 13 of the 18 nursing

districts in the Ohio State Nurses' Association have organized industrial nursing sections. Their meetings provide a type of informal staff education. Often the state industrial nursing consultant is required to be present at these meetings. Problems such as the control of absenteeism, industrial records and fundamental policies of nursing procedures always lead to lively discussions.

COLLEGE COURSE

Early in 1942 the Frances Payne Bolton School of Nursing of Western Reserve University offered a specially planned course for industrial nurses in the Cleveland area. This course was stimulated by the interest of the local industrial nursing group who appointed a committee which met with a faculty member of the school. The ensuing program was the product of the joint planning of the two groups. Topics, speakers and content were suggested and the school was responsible for the program.

The fifteen weeks' course was offered with credit and classes were held from 7:00 to 8:40 p.m., once a week. Sixty-three nurses registered for the course, most of them active in industrial nursing, some were from other fields of public health nursing. The content was geared to present-day needs in industrial health. Material requested which could not be fitted into the first semester's work was held as a nucleus for a later course.

PUBLIC HEALTH NURSING

STATE-WIDE EDUCATIONAL PLAN

The Ohio State Department of Health cooperated in this program and members of its staff gave several lectures. The United States Public Health Service and other national groups also contributed materially. The practical value of this program aroused sufficient interest on the part of industrial nurses in other areas of the State that the university planned, with the cooperation of the Ohio Department of Health, to offer a course for industrial nurses in centers outside of Cleveland, the time and place to be arranged to suit individual groups requesting it.

The State Department of Health nursing consultant in industrial hygiene, whenever possible, stimulated interest in the proposed course. The first nurse group to participate in this special course was in Youngstown.

A meeting of the Youngstown nurses was held and a representative of the University explained the program. New suggestions for the content of the course were developed, since the original course offered by Western Reserve University was a pattern cut to fit the needs of a special group.

All suggestions were carefully considered in consultation with other faculty members at the University, and course content and speakers arranged. The state industrial nursing consultant was granted time to help build the program and to give a number of the lectures. A complete schedule and bibliography were distributed to the students. This plan gave the students ample advance opportunity to study their own situation and prepare questions for discussion relative to their problems as the topics were presented.

In Youngstown the industrial nurses announced the course in the local newspaper. They kept informed the president of the local nursing district association,

the full-time nursing secretary, hospital superintendents, public health nursing organization, and announcement was made at a general meeting of the district nursing association. Management and the industrial physicians also were apprised of the project, and in some instances the plant management paid the tuition fee for the entire nursing staff and provided a relief nurse to work the 3:00-11:00 p.m. shift on the night of the class.

Seventy nurses enrolled, of which number the majority were engaged in industrial nursing and the others in private and general services. This last group was especially interested in industrial nursing and all wanted positions in industry. As a result there is now a reserve group of industrial nurses as well as the group of industrial nurses already employed, the quality of whose nursing programs was certainly affected by the content of the course.

As the course progressed interest was maintained in the community. This was aided by the excellent cooperation of the local newspaper and the personal interest of management and industrial physicians in the subject matter under discussion.

Results in the community were evident in many ways before the close of the semester. The most outstanding bit of community education was evident when a large steel industry in the area which had employed practical nurses and first-aid attendants for a number of years changed its policy and in January 1943 employed three registered nurses who had taken the university course. Another result was the action of an industrial physician at the moment contemplating a promotion for one of his industrial nurses. Before a final decision was made he called the instructor of the course to inquire about the nurse's attendance at the class and her contribution to the class discussion. A further re-

COURSES FOR INDUSTRIAL NURSES

sult was evidenced when recently a Youngstown industry approached the state nursing consultant to assist with a plan to re-arrange its dispensary.

The greatest accomplishment was seen in the gradual development of the industrial nurse's conception of the important role of the nurse in industry. Many industrial nurses helped secure standing orders for nurses to use in the dispensaries.

News travels quickly. Other industrial nursing groups throughout the state soon learned of the program in Youngstown and as a result Western Reserve University received requests to give the course in three other sections of the state—Columbus, Canton and Dayton.

The course offers two semester hours of college credit applicable to a bachelor of science degree or to a certificate in public health nursing.

REGISTRATION OF STUDENTS

There are three types of registration. One is for the regular student who meets all of the college entrance requirements and is accepted by the university for matriculation. Second is for the student who has not satisfied entrance requirements because of a deficiency in high school credits or basic nursing. This student completes the regular registration blank but is not given credit for the course. The third type of student simply wishes to audit the course; the number of these students is limited.

Utilization of the state nursing consultant as part-time lecturer has been profitable to both the State Department of Health and the University. This plan enables her to know the nurses employed in industry and provides a means for keeping them in touch with the public health nursing program and resources of the State. Since each industrial nurse enrolled in the course represents at least 1,000 employees, the health department

is able to carry forward one of its primary objectives which is the improvement of the health of workers through well-developed industrial hygiene programs. The nursing consultant's teaching has assisted in identifying the State Health Department as rendering specific services to assist the industrial nurses in their daily tasks. In the past, the health department has often been thought of as an agency interested only in occupational diseases. Furthermore, the present plans for organization and education have helped to break the strands of isolationism which have been binding each industrial nurse to the confines of her factory.

It is to be regretted that the programs of the district and annual meetings of the nursing associations have not yet interested the industrial nurse sufficiently so that she will attend these meetings, nor have these programs stimulated the employer to give her time to attend. However, the situation is improving, because the group contacts are resulting in self-development and recognition of needs. Whatever these nurses gained from the courses is tremendously augmented by their informal exchange of problems.

Many institutions are now giving satisfactory educational courses for those who are preparing themselves to become industrial nurses. These courses, however, cannot at present reach the thousands of nurses already engaged in this field. Together they form the composite industrial nurse. She cannot leave her factory to come to the university. That is why Ohio is following the philosophy of Mohammed by taking the course to the industrial nurse. One other factor in this plan warrants special emphasis and that is joint planning—and joint action.

From a paper presented before the Industrial Hygiene Institute, National Institute of Health, Bethesda, Maryland, March 6, 1943.

Is Public Health Nursing Important in Industry?

THE RELATIONSHIP of industry to public health nursing is becoming closer every day. I have been employed as an industrial nurse with Sears, Roebuck and Company, Chicago, since May 1936. This mail order plant employs approximately 11,000 people and the daily average of patients seen in the medical department varies between 200 and 250. Although most of the nurse's work is carried on in the working environment of her patients, her relationship to the physician, patient, and cooperating departments is the same in industry as in other types of public health nursing.

This company employs three part-time physicians and eight full-time nurses of which two are visiting nurses. The functions of the nurses are to give first aid to sick and injured employees under immediate medical direction of the medical director; help prevent illness and accidents; visit homes of the employees when they are ill; and assist the physician in conducting physical examinations. The nurse also gives advice and assistance to the employees in securing correction of physical defects and social maladjustments. She works eight hours a day and a five-day week.

As supervisory nurse of the plant's medical department, the State of Illinois offered me a six months' course in public health nursing on a stipend. This stipend included full transportation, tuition, and \$100 a month. I could choose the university I wished to attend providing this university gave an approved course in public health nursing. The University of Minnesota was selected and I took two quarters' work in this field. Sears, Roebuck and Company are very anxious to have their nurses do good work and felt it

would be very much to their benefit to release a nurse long enough to get the basic training in public health which is essential to the most efficient planning of really good industrial health nursing. I was granted a leave of absence from September 1942 to March 1943.

My work at the University was exceedingly interesting and everything any nurse would want to make a dream come true. I selected subjects in public health which I thought would be beneficial to industrial nursing. Every day was more valuable to me than the preceding one and it was very satisfying to see how easily this newly acquired knowledge could be applied to industry. It gave me time to think and to visualize the entire set-up spiced with public health nursing.

Since returning from the University, I have put my additional knowledge and experience to good use. In response to the interest on the part of my employer I am working out a nutrition program for the employees on a non-profit basis and giving consultant service to the manager of the cafeteria. Another goal I am trying to meet is health education adapted to the needs of industrial workers. My contributory objectives are to eliminate the elements of fatigue and to a lesser degree, absenteeism. In addition to the educational activities carried on through services to individuals there are opportunities for a general health education program for the promotion of health and safety and the prevention of illness and accidents, through classes and group discussions. Subjects included in this program are: the seasonal importance of certain health problems such as colds, pneumonia, or sunburn; activities of the medical department and other departments in

PUBLIC HEALTH TRAINING FOR INDUSTRY

industry; the effect of fatigue on production and the relation of fatigue to accidents and illness; nutrition; mental hygiene; personal hygiene; and communicable disease control. Methods used include lectures, motion pictures, pamphlets for distribution, exhibits, and newspaper articles in the plant newspaper.

My horizon has certainly been extended

since I attended the University, and I sincerely hope other states and industries will offer their nurses a wonderful opportunity of this kind. It can be an eye-opener, and by its means the company as well as the nurse may learn how to develop an adequate nursing service.

—ETHEL C. BURGESSON, R.N.

HOW TO PROTECT YOURSELF AGAINST WAR GAS

1. Stay indoors. A tightly closed room affords protection against war gas. All windows and doors should be tightly shut, and blankets (to be soaked with water) or cardboard should be kept in readiness to cover and seal shattered windows. Choose a room on an upper floor if possible; most war gases are heavier than air, although they may be carried up with air currents.

2. If caught outdoors in a gas attack, get out of the area at once. Look down and shield your eyes with your arm. Do not worry about any brief vapor exposure to which you may be subjected. The danger from this source is not great.

3. Prompt action will avoid serious effects. If you know or suspect that you have gotten any of the gas on your person or clothing, do not go hunting for a casualty station or gas cleansing station and expect someone else to help you. *Knock on the first door* you come to, and take whatever steps are necessary. Self-aid is the quickest and safest way.

4. This is what you should do. This routine should be memorized so it will be done automatically in an emergency:

(a) *Remove shoes and outer clothing and drop them outside the house, in a covered can if available. Do not touch this clothing again except with sticks or gas-proof gloves. Do not cling to false modesty. To enter a house with contaminated clothing endangers everyone in it.*

(b) *Get to a bathroom, kitchen, or laundry room as fast as possible.*

(c) *If your eyes have been exposed to liquid gas or spray, flush them immediately. Plain water out of a faucet, shower-head, canteen, or douche bag will do, but a lukewarm dilute solution of bicarbonate of soda (heaping tablespoonful in a quart of water) is even better, if it is handy. Let anyone nearby help you.*

(d) *If drops of liquid blister gas have splashed the skin, you can prevent serious burns by adequate cleansing. Promptly blot up the liquid with pieces of cleansing tissue, cloth, or a handkerchief, which should be disposed of carefully in order that it cannot contaminate anyone else. Then sponge the skin briskly with laundry bleach containing sodium hypochlorite, if it is at hand, and rinse off under the shower or in a tub.*

(Continued on page A12)



Pupil practical nurse is taught to plan and cook meals, and to adapt the family diet to the needs of the patient

Practical Nursing---A Service and a Viewpoint

By HILDA M. TORROP, R.N.

IT IS popularly supposed that general antagonism exists in professional ranks toward the training of practical nurses, but I have not found this to be the case. Where antagonism exists, it seems to rise from a lack of knowledge of the duties and preparedness of the trained practical nurse, her value and the need that exists for her services. The professional nurse properly wishes to safeguard the introduction of a group

calling themselves "nurses" and possessing no preparation for caring for the sick at any level, but the registered nurse who is concerned with the whole picture of community nursing needs also appreciates the importance of care for the chronic and convalescent patient in the hospital and in the home. Within any group as large as that of professional nursing, there will be found a certain number who take the point of view that,

PRACTICAL NURSING

although they do not wish to do chronic and long-time convalescent nursing themselves nor assist with household duties, they are also determined that no one else shall, regardless of how great the need.

To be realistic about the existing situation the professional nurse must consider questions such as these:

Would the scope of practical nursing satisfy me?

Am I willing, when on duty in homes, to do a certain amount of housekeeping?

Am I interested in the care of the long-time chronic or convalescent patient?

Can these patients pay the professional nursing fee?

It is blindness if we are to assume or to imply by our attitude that the public must take us and like us on our own terms.

In considering the recruitment, preparation and placement of the practical nurse, the most difficult problem is to reconcile individual ideas regarding this worker and what she is able to do. The fact that most doctors and professional nurses have never known, worked with or participated in the preparation of the modern practical nurse, and have never visited an approved school, makes the reconciliation all the more difficult.

ARE trained practical nurses needed? The National Association of Practical Nursing Schools at a recent meeting in New York City went on record as follows:

There is need of a large body of prepared practical nurses that can be certified as competent to perform nursing duties in the hospital and in the home. This need has grown to alarming proportions in the light of the present situation when, with the demands made upon the professional nurse, the requests for this auxiliary nursing service have increased daily. There is unmistakable indication of the need for a nursing group to fill the gap between the professional nurse and the volunteer worker—a group that, having received a thorough training at this vocational level, will look upon their

work as a dignified, useful, satisfying type of service.

The trained practical nurse is seen as vitally important because of the following factors:

1. The War

- a. Nurse shortages in all hospitals
- b. Premature discharge of convalescent and maternity patients to their homes
- c. Increase in home care of chronic patients

2. Importance of Training

The trained practical nurse can render supportive nursing service in the hospital that is not possible by any less well prepared group.

3. Cost of Sickness

Sheer economic necessity makes it impossible for many patients not acutely ill to afford a professional nurse even if one were available.

4. Expanding Services

The number of convalescent and chronic patients at present greatly exceeds the number of acutely ill.

This will be increasingly true as the men in the services are returned to this country for hospitalization.

5. Peacetime Needs

Of necessity, this will include a large number of trained practical nurses as part of the national nursing plan.

The dangers in the present situation lie in:

1. The passivity and absence of leadership shown by the medical and nursing professions toward chaotic conditions existing in the field of practical nursing—a field in which thousands of women are working. Ignorance of or indifference to the way in which countless numbers of our sick are being cared for must account for this.

2. The vast numbers of unprepared women and girls, who are nursing under no supervision whatever. They work side by side with trained practical nurses and receive the same salary. We would never countenance a practitioner within the medical and nursing professions who had no proof of preparation for his or her work. Yet we do countenance this kind of service for our patients. Persons of responsibility have been known to say



The pupil's hospital experience includes the care of convalescent medical, surgical, and maternity patients and of convalescent children

in a voice of authority: "This is no concern of ours—let each institution do as it sees fit and recruit and prepare auxiliary workers according to its need." Do they realize what that would mean—that preparation might vary in length from days to weeks, be supervised or unsupervised. Applicants might or might not be acceptable. None of these people are receiving any kind of vocational training. They will be part of the flot-sam and jetsam of the postwar situation. We are using them and they are using us—and in the end the patients are exploited! "It is not the initial cost of an error that counts, it is the cost of the upkeep."

3. The opportunities given unscrupulous commercial organizations to enroll women in so-called "courses" ranging from two weeks to a year in length. These are legion. Almost daily visitors to courses report that they were offered

a "case" that night at \$25 a week if they would enroll. There is ample justification for thinking that if suitably sponsored, vocationally sound courses were available in sufficient numbers and were given publicity and backing by the medical and nursing professions, the numbers of trained practical nurses would increase and the enrollment in worthless courses would decrease.

THE SERIOUSNESS of the situation is self-evident when workers in large numbers in every state, generally unprepared for the work they are doing, are giving care in so many cases of acute and subacute sickness. In the state of New York there were over 40,000 active practical nurses in 1938. It is apparent that legislation establishing standards for practical nursing schools and defining the duties of this worker affords protection both to the public and to the prac-

tical nurse herself. Provision must also be made for enforcement of such a law.

It is to be expected that a generous amount of time will be necessary to prepare the ground for such legislation. A problem that confronts most state nurses associations attempting to contact medical groups, women's clubs, men's clubs, political gatherings and registered nurse alumnae groups is the dearth of speakers—speakers who can present controversial subjects tactfully, firmly and clearly. A standing speaker's bureau that had as its function the interpretation of nursing in general including the problem of practical nursing, would be of cumulative value in making the task of education for legislation less difficult.

THE PUPIL PRACTICAL NURSE—1943

MODEL

A composite of the average applicants to a school of practical nursing in 1943 would seem somewhat like this:

30 years of age

2 years of high school

Usually married and has children

Has worked at many things

Always wanted to be a nurse

Wants to leave domestic, office or factory work

Is very much interested in this new field and makes a most enthusiastic student

THE PRACTICAL NURSING SCHOOL—

1943 MODEL

A composite of the formal courses in practical nursing might read:

9 months to a year in length

Definite curriculum of 200 to 400 class hours

Registered professional nurses as instructors capable of teaching at the difficult level between volunteer workers on the one hand and students of professional nursing on the other

Adequate space for class room; nurs-

ing practice room; home economics laboratory; study hall and library; dressing and locker room

Hospital affiliation providing for instruction and supervised experience in the care of patients convalescing from medical, surgical, maternity and pediatric conditions and chronic illness.

A MUCH more heterogeneous group faces the instructor in a practical nursing school than in the average school of professional nursing. The group may have in common only the desire to become a practical nurse. This means that the professional staff must be chosen with great care. Their qualifications must include liking people—all kinds of people—the aggressive, the worried, the long-out-of-school, the foreign born. They must be flexible, mature in their disciplines and possess a sense of humor. If their own nursing preparation has taken place in a militaristic atmosphere where students rise to attention in the presence of the instructor, or where informal student comments are frowned upon, there is liable to be trouble. The director and her assistant can use a knowledge of guidance techniques to advantage in helping these older women to re-evaluate any useful past experience or training they may have had so that these may serve as assets in their future vocation.

Wise counseling enables the student practical nurse to see herself clearly in the field that she is entering, particularly in her relation to the nursing profession, the medical profession and the community as a whole. She must believe that doing a good piece of work as a practical nurse is a full-time job and that, like others working with people, she needs broadening personal interests outside of her work. In selecting students, the professional staff must be able to recognize the value of home and ex-

PUBLIC HEALTH NURSING

perience background as well as that of formal education.

The instructor who teaches practical procedures must be abreast of progressive methods of teaching the nursing arts. Procedures must be presented accurately and clearly but without emphasis on underlying scientific principles as such. The instructor must know her subject matter thoroughly, must be able to select salient and important facts and eliminate non-essentials which might tend to confuse student learners. She must avoid technical and scientific terms for which the student has no background and make her subject equally vital and vivid for the woman who left school 20 years ago and for last June's graduate.

The curriculum in practical nursing cannot be fashioned after the professional nursing curriculum by cutting certain items here and there. It must be worked out from the point of view of what the practical nurse should know in order to practice efficiently. It must include simple, useful information on personal and community health, how to plan and prepare meals—no mean feat in these days of rationing—and how to keep a house in order—surely a must now that domestic workers have laid aside the mixing spoon for the blow torch. The course of study in practical nursing should include the salient points in the nursing care of the cardiac, diabetic, tuberculous and cancer patient, the patient who has a cerebral hemorrhage and the bedridden arthritic.

Even elementary knowledge of how the human body works is bound to result in more intelligent nursing care. The practical nurse should know enough about the structure of the body to understand how it is affected by illness and neglect. Such knowledge can be applied to her own health and a quick-witted teacher will find many opportunities to show how and where. A skeleton and

torso model are invaluable teaching aids.

Instruction in the techniques of recreational therapy provides the student practical nurse with useful skills. Incidentally, it sometimes serves to uncover hidden creative talents which bring her great personal satisfactions as well.

The approach to practical nurse teaching is made as to a lay group. Semi-popular articles on health and new developments in the health field are valuable reference materials. Teaching methods are important as many of the students are returning to a classroom for the first time in years and find concentration on a lecture and note-taking at one and the same time very difficult. A lesson outline on the blackboard makes coherent notes more possible. Mimeographed or textbook procedures leave the student free to give her entire attention to the nursing demonstration. Apt comparisons are helpful in explaining subject matter which is new to the group. Frequent and systematic review is especially useful.

DEMANDS for the services of the graduate practical nurse take her to the wards of hospitals for the acute or chronic ill, into homes to care for long-time convalescent or chronic patients or for the mother and baby after discharge from the hospital. Now she is also finding a place as auxiliary worker in public health nursing associations. She has been taught to take on the duties of homemaker when necessary. She is aware of the value of recreational therapy, she understands the care of herself as well as the care of her patient. Service in homes places a high premium on special qualifications. Singing, reading aloud, bridge, swimming, driving a car, shorthand and typing, a knowledge of languages—all are definite assets in long-time positions.

The profile of the most-likely-to-suc-

PRACTICAL NURSING

ceed practical nurse is much like that of any successful business and professional woman. It is a grave mistake to teach by example or precept that nurses are "different." Attention to grooming and carriage, ability to talk intelligently on current affairs, recreation and reading on a suitable level, living conditions that provide balance for a work life spent in

the sick room, an active interest in community affairs—we seek to develop these indications of social maturity in the student practical nurse, for her graduate role is exacting.

The pictures, showing activities of students in the Brooklyn Y.W.C.A. School of Practical Nursing, are by Roy Pinney.

NOTES ON WESTERN TRIP

On May 13, 1943, under the sponsorship of the American Public Health Association, a group of the representatives of various national and federal health agencies started a state-by-state tour of the western area of the United States to take part in the spring meetings of state public health associations. This arrangement was tried as a wartime substitute for the annual meeting of the Western Branch of the A.P.H.A. usually held in one city in the spring. Dr. Reginald M. Atwater, executive secretary of the American Public Health Association, made the arrangements for the trip and acted as chairman of the panel discussions in which the traveling troop participated as a body. The theme of these discussions was "Practical Problem-Solving in Wartime."

In addition to the American Public Health Association, there were staff members from the Public Health Service, Children's Bureau, American Red Cross, National Foundation for Infantile Paralysis, American Social Hygiene Association and from time to time the group was joined by speakers from universities and foundations. A distinguished British visitor, Dr. Robert Hughes Pafry, Health Officer of Bristol, England, accompanied the team

all the way and was the principal speaker at all dinner meetings. His story of Bristol under the blitz of 1940-1941 (to be published in *The American Journal of Public Health*) was both moving and inspiring and presented a timely subject which drew a large attendance from among lay people.

Besides giving each of the team an opportunity to confer on special problems, as, for example, Miss Deming's visits with the merit system supervisors and public health nurses, the local health workers in each state had a chance to get their immediate problems before the national visitors and secured an interpretation of policies to which many non-professional people in the audiences listened for the first time. The process proved educational to all concerned. During this trip approximately 3,000 people were reached, at least three times as many as usually attend the annual meeting of the Western Branch.

As a practical adjustment to wartime difficulties this method of reaching the membership of a national agency has much to commend it.

—DOROTHY DEMING, R.N.

In-service Training for Assistant Supervising Nurses

By ELIZABETH LYNCH SEWELL, R.N.

THE preparation and continued education of assistant supervising nurses in New York State have been given careful consideration by the State Department of Health. Various methods have been tried with varying results. Late in 1941 an education consultant was assigned to study the problem and recommend a course of action.

In order better to understand possibilities and difficulties inherent in the Department structure, and to evaluate methods used and the results obtained, a brief description of the structural plan is necessary.

Supervision of public health nurses in New York State means supervision of 2,087 nurses, exclusive of those employed in New York City, serving an area of 47,630 square miles and a population of 6,024,147 people. These public health nurses are employed by different types of agencies: village, town, city, county, and state departments of health, visiting nurse associations, boards of education, insurance companies, industries and other privately supported organizations. The New York State Department of Health, through the Division of Public Health Nursing, is concerned with supervision of public health nursing in the State and offers such supervision where it is needed. The visiting nurse associations, the boards of education through the State Department of Education, and health depart-

ments in the larger cities and in five counties provide supervision for their own staffs, making use in varying degrees of the supervisory and specialized consultant service available to them through the State.

The supervisory program of the New York State Department of Health is carried on largely through the 20 district health offices in Upstate New York. (Upstate refers to the State exclusive of New York City and will be the term used to designate the area served by the State Department of Health.) A district health officer and a district supervising nurse with assistants as indicated are assigned to each of 20 district areas.

The district supervising nurse, under the general direction of the district health officer who represents the State Commissioner of Health, is responsible for the improvement of the quality of public health nursing. She receives administrative and consultative assistance from the director of the Division of Public Health Nursing and from assistant directors and consultants in specialized fields including education. All of these have headquarters at the central office in Albany, but are available for field service.

Until January 1942, the preparation of assistant supervising nurses was largely on an individual basis. Each nurse preparatory to or after assuming supervisory responsibilities was given additional train-

TRAINING ASSISTANT SUPERVISORS

ing in one of the district offices, usually in the area in which she was to function in her new capacity. There were some disadvantages as well as advantages in this method. Training varied in different districts according to the time available for guidance of the new assistant who was to some extent a "lone worker." She lacked the benefits inherent in the close associations of a gregarious working group, which adult educators have found a requisite for a successful learning experience. But the chief factor was time, and at this date, following soon after Pearl Harbor, the acceleration of in-service training programs without sacrificing quality became increasingly important.

The need for intensive in-service training for assistants was indicated by the lack of prepared personnel to fill existing vacancies caused by staff changes due to war, and also to an increase in the number of public health nurses employed—in itself a concrete acknowledgment of the contribution of public health nursing in maintaining civilian health. Also needed was additional training for some nurses functioning as assistant supervisors. Consequently a plan was made combining the most desirable elements of a centralized and decentralized in-service training program for nurses undertaking supervisory responsibilities either as assistants or as senior advisers.

FORMULATION OF PLAN

An education consultant in public health nursing was responsible for the general direction of the program. Both in the formative and in later stages the plan was discussed with, or rather developed from suggestions of consultant nurses, the nursing director and assistant directors, medical directors of divisions, district health officers, district supervising nurses, assistant supervising nurses, senior advisers, and staff nurses showing poten-

tiality for supervision. Directors of nursing of city and county health departments and visiting nurse associations were also consulted since their problems in developing supervisors were comparable to those of the state nursing service. Thus all concerned contributed to the plan evolved.

The introductory period in public health nursing supervision was planned to provide an opportunity for acquisition and application of knowledge, experiences, skills, and attitudes needed for optimal performance in supervision.* The course was offered to a group of selected public health nurses who had demonstrated outstanding ability. These came from city, county and state health department staffs and from visiting nurse associations. Two groups participated during the year, 13 in the first group, 19 in the second.

The expected outcome was stated when the general plan was formulated: public health nurses who have had this experience will be prepared to give an increasingly better service in the field through improved understanding of administrative and supervisory practice, and with guidance, to assist in a program of nursing supervision.

More specific objectives were stated:

Nurses in this group should learn principles of supervision and organization, and the historical background, development, and current programs of the health department and other state agencies through accurate, uniform presentation and group discussion.

Methods of supervision should be discussed and analyzed by the group.

Time and effort in the district office should be conserved by concentrating the above activities in one place and at one

* Adapted from The Public Health Nursing Curriculum Guide. Joint Committee of the N.O.P.H.N. and The U. S. Public Health Service, 1942.

PUBLIC HEALTH NURSING

time, rather than repeating in several offices.

Supervising and senior advisory nurses working in official and nonofficial agencies should participate in a discussion of common problems in the interest of greater coordination of all nursing services.

Group members should practice application of methods and principles of supervision in their respective districts under the guidance of the district supervising nurse or agency nursing director with the education consultant functioning as a coordinator and adviser.

An increasing number of nurses should be quickly, adequately and economically prepared to function in a supervisory capacity.

PROCEDURE FOLLOWED

General plan. The original plan was that nurses should spend five days in central office conferences; the following six weeks in the field applying principles and methods learned; then an additional five days in the central office to review and evaluate theory and practice undertaken. The field practice period was changed to ten weeks for the second group, following suggestions from the participants.

Preparation of nurses. Assigned references were read on principles of supervision, historical background, programs and accomplishments of the health department. District office conferences were arranged on such subjects as health needs, plans and accomplishments; methods used in program planning, such as the use of the tuberculosis, syphilis and gonorrhea, and cancer case registers; and analysis of the nursing service.

Preparation of group leader (educational consultant). Study was made of the background of each participant by reading personnel records and by means of conferences with each supervising nurse. This provided some indication of individual abilities and needs. Division directors and others who would assist in the program were consulted and acquainted with the general background of the group. Considerable reading was done by the ed-

ucation consultant in preparation for her role as general chairman of all meetings and as leader of those pertaining to methods of supervision.

CENTRAL OFFICE CONFERENCES

A. Content

First session (early in experience). Conferences related to:

- Governmental organization
- New York State Department of Health organization
- Programs, facilities, and relationship of the divisions of the health department
- Programs and facilities of other departments—education, social welfare, mental hygiene
- Supervisory principles and related procedures

- Field supervision—home visits, clinics, classes, conferences
- Group discussion methods
- Personnel guidance

Second session

- Further analysis of supervisory principles and procedures
- Student program
- Lay participation
- Public relations
- Nursing in wartime
- Laboratory facilities

B. Methods used

New material was presented by a combined lecture and discussion method. Material with which members were somewhat familiar was presented in group discussion.

The workshop plan was used for material which could be developed by small groups. This particularly interesting experiment demonstrated the value of the activity concept in learning. Participants divided into small groups, sat around a table and worked out a project such as a talk to a medical society, to an appropriating governmental body, or to a class of expectant mothers. A chairman was selected by each group. Some reference material was available, and group members had access to the library. A consultant nurse sat with each group but did not direct the discussion or findings. Following completion of some phase of its project by the various groups, all members assembled and each chairman reported to the whole group. She explained

TRAINING ASSISTANT SUPERVISORS

the project selected and its objectives, discussed the methods to be used, and then demonstrated how such methods might be used in an actual situation. Each chairman was so engrossed in presenting this product of group thinking that the result was a situation as near real as might be achieved in a classroom. This was in marked contrast to a previous experiment when selected individuals presented the same type of material. Then each individual was so intent upon the presentation of her own product that in most instances she became uncomfortable in an artificial situation. Group members were unanimous in their approval of the "workshop" technique.

Demonstrations were used whenever feasible. A home visit was made the basis for discussion of teaching procedures as demonstrated and recorded. Mimeographed copies of the record had been distributed. The demonstration was also used to determine principles of supervision involved.

Following discussion, field trips were made to the State Departments of Education, Social Welfare, and Mental Hygiene, the Bureau of Vital Statistics, Public Health Education including the workshop and theater and the laboratory.

The blackboard, charts, demonstration material, films and other visual aids were used.

Pretests were used to help diagnose individual needs in the broad areas covered.

"Information Please," the final group session, was conducted with the "experts"—directors and consultant nurses—questioned by group members. This was an especially valuable and enjoyable meeting.

C. Assignments

Assignments, some to be completed within the six weeks' (later ten weeks') interval between central office conferences, and some to be finished within a six months' period, were related to activities which might normally come within the scope of an assistant supervisor's work. Typical assignments are:

- Case load analysis
- Appraisal of local health services
- Community survey
- Activity records
- Monthly reports
- Work plans
- Special assignments related to the district

FIELD WORK

Application. The interval between group conferences was a working period during which the assistant supervising nurse had an opportunity to observe, plan, practice and to receive continuous guidance in supervisory procedures. A planned program included conferences and field trips with the district engineer, supervising nurse and health officer. A detailed outline suggesting content of conferences and observations was sent to each district office. Each assistant worked on assignments under the guidance of the supervising nurse.

Consultation service. The education consultant visited each district, offering advisory service in guiding and evaluating the progress of the student assistant supervisor. This included help in the application of the principles and methods of supervision, and also consideration of the special project undertaken by each. Typical projects related to improvement of activity records, studies of opportunities in public health nursing in local industries and schools of nursing, and analysis of success or failure in the examination of contacts in the tuberculosis service.

Evaluation. Accomplishments were evaluated by improvement in field practice. This included relationships with nurses and other workers, methods of supervision, research, recording, and suggestions made for desirable change.

Group members generally showed a satisfactory degree of progress in field work—in increased interest, in the preparation of concise, informative activity records and monthly reports, and in thoughtful evaluation of this experience. Certainly an inquiring attitude was developed. Three members of the group have undertaken postgraduate study.

PUBLIC HEALTH NURSING

Group members found their greatest difficulties to lie in adjusting to new district work and in dealing with personality problems affecting themselves and others.

GENERAL CONCLUSIONS

The pattern described provides a satisfactory in-service training program in supervision.

Intensive work with individuals in the field of personnel relationships is desirable following the economical but more general method of group instruction. The number of the group should be limited to permit intensive consultant service. Or sufficient time should be planned well in advance if a large group is to be taken.

Careful selection of candidates is essential.

The entire program, central and district office conferences, observations and other activities, should be based on sound educational concepts which include learning by doing, utilizing previous experiences, interaction with other individuals, considering problems which originate in the field, and appreciation of proper evaluation techniques as part of the whole process.

The whole program from its inception should be based on the needs and suggestions of those who will participate and also on known situations in which they will be expected to function.

A BENEFIT OF WAR

PEDRO was devoted to his wife and seven children—during the brief moments when he was home and not flitting away after any new love who might flash her teeth and roll her eyes in his susceptible direction.

Recently Pedro's absence from home was longer than usual. Mrs. Pedro, usually reconciled to her lot as second choice, became worried. She asked the public health nurse to get in touch with the proper authorities.

Finally a letter came with a strange postmark. When Mrs. Pedro opened it she was greeted by the salutation, "My dearest and only one." Pedro had been inducted into the army and he was enjoying the new life.

So was Mrs. Pedro. She was now nearest in line not only for this wonderful salutation but also for a \$120 monthly soldier's dependency allotment.

—IN THE 1942 ANNUAL REPORT, VISITING NURSE
ASSOCIATION OF HOUSTON, TEXAS

Application of Certain Business Methods To Nursing Organizations

By THOMAS W. SCOTT

BEFORE 1920, most nursing associations were operated on a "Lady Bountiful" basis—with few controls and a general lack of record keeping. During the ten-year period between 1920 and 1930, however, many associations made rapid strides in applying business principles and methods to the management of their organizations. Substantial improvements were made in their record systems, not only case records and supplementary records but also in financial records. Perhaps the most important step was a move toward standardizing records so that the results in terms of cases, visits and costs were comparable among most of the private visiting nurse agencies.

In the next ten years, 1930 to 1940, progress was still greater, and now nursing agencies enjoy the unique position among social agencies of having a fairly uniform, standard method of reporting their accomplishments and cost of operation. Today, because of the war emergency and the shortage of nurses, it is more important than ever to adhere to business principles and improve management methods as much as possible.

The management methods advanced to agencies during the past 20 years through the National Organization for Public Health Nursing and other sources is part of a well-defined plan. The intent of this article is to review progress and discuss some of the planning and method principles that are yet to be applied.

During the 20-year period in which associations made such strides in improving their record systems, advances were made not only on case and supplementary records but also in the direction of setting up fairly uniform bookkeeping, transportation, attendance and other records. Following the adoption of record systems, there was a long period devoted to the improvement of financial records. Most associations now have rather good records of income and disbursement, subdivided as to source, and most have a budget which is broken down by activity. In addition, all of the large and quite a few of the small visiting nurse associations now prepare a cost-per-visit statement on an annual basis.

Because agencies do have some uniformity in their records, attempts have been made to set up some standards of performance. These standards have by no means been officially adopted, and there is a need for some measuring rod to determine whether the agency is giving the community the best possible care for the least possible cost. Some unofficial standards, however, that have been established and are on a working basis are: cost per visit; cost by account, that is, the amount such factors as rent, transportation, etc., contribute to the unit cost per visit; the weighted number of visits per nurse each year; the average number of visits per cases by diagnosis; the time per visit subdivided per office, travel and

PUBLIC HEALTH NURSING

time in the home; the expected volume of cases in relation to population and amount of insurance in force; the average distance between cases; and many other factors which have been most useful in analyzing and diagnosing an association's problems.

ALL the foregoing is but a thumbnail sketch of some of the things that have been accomplished to date. The listing is by no means complete, nor can it be said that perfection has been reached in any one of them. The program for the future could well include improving the tools that the associations now have to work with, and increasing the skill of the director and her associates in the use of them. Thought could well be given to some of the following points. For instance, improvements in salary scales have not been too generally adopted and there is need to renovate them to reflect increases in salary based not only on length of service but also on quality of work and capacity to advance to higher positions. Another tool which might be developed further is the cost-per-visit statement. Although most associations prepare such a statement, it is recognized now that there is still room for improvement because agencies are finding a need to express their unit of various types of service in a more accurate manner. Very little has been done in the direction of determining cost by activity, for example. The per cost statement is limited entirely to the average cost of the home visit, and an analysis of the remaining expense applicable to other activities such as clinics and classes, et cetera, is not often made today. These costs in turn could be allocated to the activity for which the money is expended and expressed as a unit cost—such as the cost per baby visit to a well baby clinic.

In addition to such improvements, the future may also bring an application of other techniques that have not yet been generally employed, even though many agencies have consciously or unconsciously applied part of them.

These new techniques include Functional Analysis, Duty Coordination, and Work Simplification. They may be compared with three types of microscopes. Functional Analysis permits a view of the whole field through a low-powered lens; Duty Coordination is an analysis of the several jobs performed by an individual to accomplish a given function, and makes it possible to study one position or a part of a field through a medium lens. Last but not least comes Work Simplification which is an analysis of the different actions in one specific job. This is comparable to a high-powered lens and permits a detailed examination of every part of each job that makes up a position.

A FUNCTIONAL ANALYSIS is made by charting all the objectives which the agency wishes to accomplish and then, under each objective, the activities that are performed to accomplish the objectives. It is then desirable to study our organization chart to determine if we have the proper setup to carry out the activities of each of these three, i. e., objectives, activities, and organization which act as a check and balance on each other. When listing the activities, it is necessary to show each individual that carries out the whole or any part of the activity. When this picture is complete, the policy-forming group (the board of directors, the director of nurses, and any others) are able to look over the entire field, which may be the whole community, or only the individual. The group can then determine whether the association is performing functions unrelated to the objectives;

BUSINESS METHODS FOR VNA'S

whether there are any functions missing; and whether there is any overlapping or duplication of function or authority.

DUTY COORDINATION, the medium lens, is a study of each class of work performed to complete an activity. The Functional Analysis chart has shown us the listing of all the activities and who performs them, and the next step is to break down these positions and study the order and arrangement of the jobs included in each position and the time required for each one. Our goal is to arrange the work into natural groups so that each individual is performing work, the proper work. It would not be economical to have the director of a visiting nurse association perform clerical work that could be assigned to one of the office clerks. An illustration of some of the results that might be obtained is given by a recent study of a laboratory procedure which indicated that part of the technicians' time was spent washing glassware. A time study of each duty performed by these technicians made it possible to add up the glass washing time of all the technicians and it was found that this duty could be taken away from them and turned over to two porters. In another case, a group of 10 clerks were performing a job requiring some calculation. Each clerk had a calculating machine and each was fairly highly paid because she possessed the necessary skill to run a calculator. A breakdown of the job revealed that about one half of their time was devoted to a "Get Ready" operation, that is, the material was removed from the file and sorted into its proper order. Then certain factors were calculated, which required about one tenth of the total time. The remaining four tenths was devoted to a "Put Away" operation, which consisted of posting the results of

the calculation into a ledger and preparing the material to be refiled. The analysis resulted in these obvious changes: first, five low salary clerks could handle the "Get Ready" operation which not only saved the high salary cost but simplified and shortened the job-training time; second, one individual was retained to do the calculations, which enabled the group to release four machines badly needed elsewhere in the office; and third, four lower salary clerks were assigned to do the "Put Away" operation. This also reduced the salary bill and shortened the training time for this job. This type of analysis can be applied to every employee of the agency from the director to the janitor.

WHEN we look at the various classes of work under our high-powered microscope, we are no longer concerned with where the work is coming from, or where it is going to, but rather how can this specific task be accomplished in the most simple and easy manner. This brings us to the field of Work Simplification.

The nurses or clerks of an agency can be considered efficient only when they apply their efforts to their daily work with such wisdom that the work is completely, properly, and successfully done with the least amount of energy, materials, and time. Any procedure that requires them to perform a task in less time than was formerly taken without showing how to eliminate useless and wasteful motion is bound to require speeding up. As a result, the employee is forced to hurry, and it is perfectly natural that resentment and perhaps a decrease in the quality of the work may occur.

Increased productivity attained by the application of Work Simplification methods is not a speeding up process. There is a difference between work that is done

at high speed and work done in a hurry. The former can be perfect work because it is done by eliminating unnecessary motion, whereas the latter may be poor work because it is a speeding up of *all* movements, both necessary and unnecessary.

Work is completely productive only when waste and non-productive motions have been eliminated. A study of each step in a given job and the motions required to perform it provides a relatively simple means of analysis through which it is possible to weed out and eliminate useless motions. This means the same or a greater amount of work with less expenditure of effort.

In order to visualize clerical or professional procedures clearly as a whole, it is necessary to chart the procedure in the exact sequence that the work is performed. A suggested chart form is included with this article. It represents one page of an actual analysis that was made in a nursing organization where the problem was to read mail; sort it into various classes; and prepare replies by inserting different combinations of form letters, fliers and other material in an envelope. It was decided that these replies could be prepared in advance and this assembled material (complete with envelope) was arranged on racks on a table. This avoided the necessity of gathering material from various shelves about the room. It eliminated a lot of unnecessary reaching, bending and walking and the operator could now be seated while at work. The racks were arranged on the table within easy reaching distance. The assembled replies were addressed by use of typewritten, gummed stickers. Some special gadgets were used to facilitate the collating of the material to be inserted in the envelopes. Briefly, the whole job was made easier for the clerk and the change

resulted in a substantial increase in production.

The study of the original method showed that 70 operations and 10 transportations were made on a letter before it actually left the office, and that, in gathering the material for reply, the clerk must move approximately 170 feet. When the entire procedure was reviewed by the director and her associates, it was obvious that many operations could be eliminated and that a rearrangement of the material was desirable in order to avoid unnecessary transports. The proposed method reduced the number of operations to 12; the number of transportations to 4; and the distance traveled to 55 feet, or a saving of 58 operations; 6 transportations; and 115 feet in travel. This analysis was made by preparing a Process Chart, which records the successive steps of a procedure arranged in the proper sequence of the work that is performed. All steps are recorded on the chart to present a bird's-eye view of the details of a procedure in condensed form. The chart does not simplify, but is merely the visual presentation of the procedure which in itself may suggest logical methods of simplification.

THE Process Chart is simple to construct. Symbols are employed to describe each step in the course of the performance of the work as follows:

- | | |
|-------------|------------------|
| ○ Operation | ○ Transportation |
| △ Storage | □ Inspection |

The large circle denotes an operation such as "prepares case record." The small circle denotes transportation of materials or persons moving from one place to another. The triangle denotes a storage, meaning that the item is stationary and awaiting further action. This may be permanent storage or temporary storage. The square denotes an inspection, such as "review of

July 1943

BUSINESS METHODS FOR VNA'S

PROCESS CHART																																					
Completion of form letter, Code #1, replies CHARTED BY: Clearing Bureau CHART NO. 1 SHEET NO. 3					SUMMARY <table border="1"> <tr> <th>METHOD</th> <th>TIME</th> <th>PROP.</th> <th>SAVING</th> </tr> <tr> <td>NO. OF OPERATIONS</td> <td>70</td> <td>12</td> <td>58</td> </tr> <tr> <td>NO. OF TRANSPORTATION</td> <td>10</td> <td>4</td> <td>6</td> </tr> <tr> <td>NO. OF STORAGES</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>NO. OF INSPECTIONS</td> <td>3</td> <td>0</td> <td>3</td> </tr> <tr> <td>NO. OF MINUTES</td> <td></td> <td></td> <td></td> </tr> <tr> <td>DISTANCE TRAVELLED</td> <td>170</td> <td>55</td> <td>115</td> </tr> </table>					METHOD	TIME	PROP.	SAVING	NO. OF OPERATIONS	70	12	58	NO. OF TRANSPORTATION	10	4	6	NO. OF STORAGES	0	0	0	NO. OF INSPECTIONS	3	0	3	NO. OF MINUTES				DISTANCE TRAVELLED	170	55	115
METHOD	TIME	PROP.	SAVING																																		
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DATE: 194 DIVISION: SECTION:					CAN I CHANGE SEQUENCE? CAN I SIMPLIFY?																																
DIST. IN FEET	TIME IN MIN.	OPERATION	DESCRIPTION OF PRESENT METHOD	DIST. IN FEET	TIME IN MIN.	OPERATION	DESCRIPTION OF PROPOSED METHOD																														
			Clerk gets up from desk				Other duties at desk																														
25			Goes into next office				Gets up from desk																														
			Obtains inquiries from storage box	5			To storage box for inquiries																														
25			Returns to desk	5			Returns to desk																														
			Places inquiries on right side of desk				Places inquiries on desk																														
			Sits down at desk				Sits down																														
			Opens second drawer left side of desk				Insert address label in typewriter																														
			Removes supply of envelopes from drawer				Type address label																														
			Places envelopes to right of typewriter				Remove prestuffed envelopes from rack																														
			Closes drawer				Stick address label on envelopes																														
			Opens top drawer left side				Insert special pamphlets as requested																														
			Removes folder				Pick up addressed envelopes																														
			Places folder on left side of desk				Gets up from desk																														
			Thumbs through folder for instruction sheet	5			To "State List" rack																														
			Glances through instructions				Select State List																														
			Picks up envelope				Insert in envelope																														
			Inserts envelope in machine	40			Take envelopes to General Office																														
			Types name and address from inquiry																																		
			Removes envelope from typewriter																																		
			Opens lower right hand drawer																																		
			Removes supply of "special" pamphlets				Note: The description of the																														
			Closes drawer				"Present Method" is actually																														
			Places "special" pamphlets to left of typewriter				three pages long. However,																														
			Inserts "special" pamphlets in envelopes				the results of the entire																														
			Place envelope on right side of desk				procedure are summarized at the																														
			Picks up inquiry				top of the Process Chart.																														
			Places inquiry to right of unanswered inquiries																																		
			Gathers together addressed envelopes																																		
			Gets up from desk																																		
5			Goes to supply cabinet																																		
			Pulls necessary State lists																																		
			Places list on top of each envelope																																		
15			Goes to another supply cabinet																																		
			Removes supply of letters from shelf																																		
10			Returns to desk																																		
			Sits down at desk																																		
			Places form letters on right side of desk																																		
← TOTAL				← TOTAL																																	

PUBLIC HEALTH NURSING

a case record." These symbols are connected by a straight line in constructing the chart so as to show graphically the flow of work. The exhibit entitled "Process Chart" is a sample of the type of graphic analysis which may be helpful. If a simpler method could be evolved, it would be in order.

The chart usually begins with a phone call, form, or material entering the agency, or a person starting to perform a job, and follows the subject through every step until completed. Anything that is a part of the regular routine of the job should appear on the chart. Beginners usually overlook detail and consequently do not convey the exact picture. If the chart is properly prepared, however, it is easy to cut out unnecessary detail, transports, and storage. In short, a job usually consists of three main operations: "Get Ready"; "Do"; and "Put Away."

Every director knows that the "Do" operation is frequently a relatively small part of the whole procedure, particularly in nursing techniques, therefore, it is desirable to eliminate as many "Get Ready," "Put Away" operations and "Transportations" as possible.

In analyzing the work, a questioning attitude should be adopted toward everything connected with the job. The necessity for every detail that surrounds the job should be given careful thought, and nothing should be taken for granted just because it exists at the time the study is made. When analyzing the work of your nurses or clerks ask yourself:

1. *Why* should the work be done?
 2. *What* is to be done?
 3. *How* is the work to be performed?
 4. *Who* is to do the work?
 5. *Where* is the work to be done?
 6. *When* is the work to be done?
- Why should the work be done, and

what is to be done are really questions of policy. The remaining questions three to six are administrative.

Raise the following questions in connection with the manner in which the work is to be performed:

A. Is there any unnecessary writing or copying?

B. Is proper equipment supplied to the nurse or clerk, and is it properly arranged?

C. Is the work checked and how frequently?

D. When would an error probably be caught if present checking were eliminated?

E. Would errors cause serious results?

Who is to do the work means questioning what type of employee is to perform the operation, and it may well develop that a high-salaried clerk is doing a job which might be performed by one of lower salary, or the nurse is performing an operation that could be done by a clerk or auxiliary worker.

Where is the work to be done might give an answer which results in a move to a more appropriate location within the office, or in a decision whether the work (such as completing a case record) should be done in the field or in the office.

In connection with the location of the work, question the following:

A. Does the step record information which has been or will be duplicated elsewhere?

B. Could the same result be obtained more easily at another point in the procedure?

C. Is the work brought and removed by another nurse or clerk, or by passing from one person to another?

D. Does the employee have to leave the desk to secure the material, to deliver it, or to perform the work?

E. Can the employee's desk be moved

BUSINESS METHODS FOR VNA'S

closer to other desks to facilitate receipt or delivery of material?

F. Does the employee have to go from one place to another to perform the work?

G. Should the desk be arranged close to special equipment or files?

H. Does the office arrangement permit individual conferences without interfering or interrupting others?

It is desirable that work should flow from desk to desk so that finished work at each desk can be transported to the next desk with a minimum of effort and distance traveled. Unnecessary moving about of the staff should be avoided.

By placing people close to essential records and equipment great economy in time and distance can be effected. Possibly the centralization of several related records will result in economy of operation. Good office layout will reduce the nurse's office time and reduce errors.

When is the work to be done deals with the sequence of the operations in a process and frequently savings can be made by changing the order of the operations. Relative to this, develop the following:

A. Does the work duplicate work performed at other points in the procedure?

B. Does the work require a new review of the transaction? Avoid a series of new reviews as the work progresses for each one takes time.

C. Is the step performed in the right place in the procedure? In our questioning, we must always ask ourselves:

A. Can this be eliminated?

B. Can this be combined?

C. Can the sequence be changed?

D. Can this be simplified?

It is important when studying a job to observe that any job performed in the office or the home conforms to these principles of motion economy. There are certain fundamental principles which permit the maximum amount of productive effort

with a minimum of fatigue. Some of them are as follows:

1. Arrange work within the proper working area, that is, the work should be placed so that reaching, bending, or walking is reduced to a minimum.

2. Pre-position materials, such as bag contents, etc.

3. Use the least motions possible, that is, finger motion alone is easier and quicker than finger and wrist motion. In turn finger and wrist motion is more easily performed than where the entire arm is involved. Arm movements alone are more quickly performed than a combination of arm and body movements.

4. Perform the work with both hands wherever possible.

5. Provide good conditions for posture and sight.

6. Reduce to a minimum the holding of work by either hand.

A brief illustration of the application of these principles is afforded by a recent study of a nursing organization. A clerk gathered 48 different lists from shelves that ranged from floor level to a point almost out of reach. It took a great deal of time and effort to gather these lists. A gathering rack was substituted for the straight shelving. This consisted of two identical fixtures placed on a table and each containing 24 slots in which each list was placed. The girl could then sit at the table and with a minimum amount of body motion, and therefore considerably less fatigue, "pull" the lists many times faster than under the old method.

AN analysis of the functions performed by an agency to meet suggested objectives will result in valuable, and frequently very surprising, results. Duty Coordination is brought about by carefully studying the jobs performed by each

PUBLIC HEALTH NURSING

individual; and simplifying the method of performing these tasks. To make these studies is not difficult and anyone, after a little training, can make a very creditable survey. There is no magic formula by which these results can be produced and the value is in direct relation to the thought and care that is put into it.

The intent of this article is not to cover in detail the method of analyzing the functions performed by an agency and how they are carried out, but rather to give a picture of the types of available tools which may be employed by an agency. These are in addition to such tools as cost-per-visit statements, and measurements of performance, that have

been usefully employed by the agencies to date, and with which all nurses are familiar. If the leaders in the nursing profession believe that the suggested tools will be useful, we are confronted with the problem of disseminating this information to the agencies in a practical way. Perhaps some of these principles might be included in the various college courses, and it might be equally useful to have some nurses specialize in making use of these tools so that they in turn can actually go out in the field and demonstrate their use on the everyday problems encountered by the agencies, or an alternative, if conditions permit, might be to hold a series of institutes on the subject.

What to Read, Board and Committee Members!

Mr. Scott's discussion of time-saving office procedures as they apply to nursing agencies will interest board and committee members concerned with stretching too few personnel to fulfill too many calls upon service. And which of us is not guilty of lost motion in our daily work. Incidentally, Mr. Scott's analysis chart might also be applied in a general way to home management especially when a not-too-well mother must be shown how

to save her strength in every possible way. Eduard C. Lindeman in a recent talk said that "absenteeism" is one of a half dozen or more subjects in the general field of health and welfare that have caught the public interest. Lucille Harmon tells how public health nurses can help reduce absenteeism. Two new publications of the N.O.P.H.N. are announced on page 416, both of importance to lay members.

Absenteeism

By LUCILLE HARMON, R.N.

THE PROBLEM of absenteeism is widespread; it is seriously affecting the war effort; and it has not yet reached its peak. What the public health nurse can do to help control the situation is open to question; in some plants, only about 10 percent of absences are caused by illness. In communities where absenteeism is acute, facilities for child care, supervised recreation, and other devices to help the situation are already overtaxed or are so set up that they cannot meet the needs of shift workers.

Mass approach to the problem by appeals to patriotism and by systems of rewards or punishments have failed. The individual approach by, among others, the public health nurse may be more effective than any other method. But this presupposes that the public health nurse has an

awareness of the gravity of the problem and a close working relationship with management. The most important single factor in reducing absenteeism is the feeling that the worker is needed on the job, that his absence really makes a difference in getting out production and in winning the war.

Areas in which the public health nurse can be of definite help include her evaluation of the factors in the home situation which contribute to the worker's absence, her evaluation of the worker's health status and of his attitude toward his work, his fellow workers, his foreman and the company's policies. These are primary motivating factors in work attendance.

The problem embraces so many factors that it is not possible to discuss them in detail. The more obvious might include:

I. Absence because of fatigue

Function of the
public health
nurse

A. Try to find the cause

1. Prolonged working hours
2. Poor nutrition
3. Transportation difficulties—especially in outlying areas
4. Overcrowded home
5. Prolonged night work
6. Domestic discord
7. Ride sharing and stopping at taverns
8. Physically inadequate for the particular type of job the worker is doing

B. Try to solve the problem

1. Through approach to the worker
2. Through family cooperation
3. Through discussion with plant physician, nurse or personnel director

PUBLIC HEALTH NURSING

II. Absence because of emotional instability

A. Evidenced by physical symptoms

B. By attitude toward work

Function of the
public health
nurse

1. Sympathetic understanding of the problem
2. Mental hygiene approach
3. Interpretation to the industrial physician or to management

III. Absence because of the aging process

A. Evidenced by easy fatigue, physical or mental depression

Function of the
public health
nurse

1. Referral to a private physician for examination and supervision so that worker's capacities may be determined
2. Interpret older worker and his limitations and capabilities to management so that job may be adjusted to his capacity

IV. Absence because of home responsibilities

A. Illness of other members of family

Function of the
public health
nurse to suggest

1. Visiting nurse care
2. Nursing aide care
3. Arrangement with relatives or paid care of neighbor

B. Care of children

Function of the
public health
nurse to suggest

1. Day nursery or nursery school
2. Licensed foster home care
3. Nurseries established by industry itself on a 24-hour basis
4. Paid neighbor care

C. Medical and dental care for children

Function of the
public health
nurse to suggest

1. Red Cross Motor Corps for transportation
2. Arrangements with friend or neighbor

D. House work, meals for children, et cetera

Function of the
public health
nurse to suggest

1. Contact high schools for home service from members of groups such as Victory Youth Battalion; housekeeping, or other community services for the purpose
2. Women work split hours, perhaps half time; neighbors pair up for opposite shifts

V. Absence among women

A. Because of menstrual difficulties

Function of the
public health
nurse

1. Instruction in hygiene
2. Interpret to management need for women to have more rest
3. Interpret types of work women not constituted to perform

ABSENTEEISM

VI. Absence because of poor housing, insanitary conditions, et cetera

Function of the
public health
nurse

1. Present analysis of situation to health department, civic organizations, council of social agencies, et cetera
2. Interpret housing conditions to plant management

The public health nurse's most important contribution in controlling absenteeism is her approach to and understanding of the individual worker's problem, her ability to interpret the problem to management, and her analysis of community conditions which aggravate the problem.

IN the following instances, a visiting nurse helped to reduce absenteeism:

Mrs. S. had her baby at home and her husband had to remain away from his work in a defense plant to take care of her. On the second day after her delivery, the visiting nurse was called. She went in daily and gave nursing care to mother and baby, and helped the family arrange for the daughter of a neighbor to give interim care. Thus the father was able to return to work eight days earlier than he would have had the nurse not been called.

Two expectant mothers living on the same street were antepartum patients of the visiting nurse. Neither of them had been able to arrange for care during their confinements, and both were planning to have their husbands stay home from work during their postpartum periods. The nurse made the two women acquainted, and helped them work out a plan whereby each took care of the other, except for the actual bedside care which was given by the visiting nurse. This same plan has been worked out in two other cases where neighbors expected their babies at wide enough intervals so that this was possible.

The visiting nurse was called to give nursing care to an elderly woman who had a severe heart condition. The patient lived with her daughter and son-in-law, both of whom were employed in war industries. When the mother became ill, the family was not able to get either practical nurse or housekeeping assistance and the daughter stayed home from work to care for her. The visiting nurse contacted the family physician and with his permission helped the family arrange for the patient to go to a nursing

home. After several contacts, she was able to obtain the patient's consent to go, which the family alone had been unable to do. Not only did the patient get more adequate care there, but the daughter was able to return to work.

Mr. M., a war plant worker, had a draining incision in his chest. He was ambulatory and able to work, but his wound had to be dressed twice a week and there were not adequate first aid facilities in the plant for it to be done there. Rather than have him miss two half days of work a week in order to have his doctor dress the wound, the physician called the visiting nurse who was able to adjust the hour of her call to the patient's free time and help him keep on the job.

Mrs. V. was hospitalized and although the defense industry in which Mr. V. was employed permitted him to change shifts so that he could be home during the hours in which David and Mickey were home from school, the plan was not entirely satisfactory. Mr. V. needed to leave home at 6 a.m. and he returned at 4:30 p.m. Mickey, a first grader, left for school at 8:30 a.m. and returned at 4:30 p.m. and David, a kindergarten student, returned at 12:30 p.m. Thus, Mr. V. still felt he needed to be home because four-year-old David would be alone during the afternoon. The visiting nurse worked out a plan with the school. The boys were permitted to have their lunch at school and David to remain in school until 4:00 p.m. until his mother returned from the hospital. This plan is not ideal, but at least it seems better than having Mr. V. stay home from work.

Family set-up: mother, father, 4 children—ages 7, 4, 1 and newborn.

The father was compelled to remain home from work to care for the family when his wife was confined. The visiting nurse was called in to give postpartum care to mother and newborn. Realizing what this situation meant, both to the family and to the defense plant where the man worked, the nurse was instrumental in placing a "home nursing aide" in this home. With some additional help from a neighbor the man was enabled to return to work.

PUBLIC HEALTH NURSING

Family set-up: aged father and daughter, age 40 and a wage earner.

Daughter had been employed at a laundry for many years and had been a most steady worker. Then came a period when her absenteeism became frequent. Her excuse was that she had not felt good or that she had not slept well. Finally she said that her father was ill. Since her reasons were so vague and she seemed so upset, the company decided to send a visiting nurse to investigate and see if something could be done to help her. The visiting nurse went in and found the father not only physically but mentally ill.

Their physician had prescribed for the physical complaints but because of the father's mental condition he was unable to take care of himself. Because there was no one else at home the daughter stayed there as much as possible to watch and care for her father, but hesitated to tell anyone of her situation because of her father's mental condition. The visiting nurse quickly recognized the need for immediate care. She called the family physician who gave her permission to proceed. She then called the city physician's office and a doctor was sent out immediately. Within two days the father was hospitalized and steps taken to have him institutionalized. The daughter was more than relieved and happy to know that her father would have adequate medical care and proper attention so that he would not harm himself or others. She was able to return to work comfortable in this thought and became the same steady dependable worker she had been before.

Family set-up: father—a chronic invalid, mother, two boys—ages 16 and 20.

The older boy in this family works at a defense plant. He is the sole wage earner except for the small amount which the 16-year-old boy makes at Kroger's where he works after school. When the mother fell and sustained several fractured ribs, it became necessary for the older boy to remain home from work and care for his mother and father and keep house. The visiting nurse was called in to give nursing care. She recognized the need for this boy to return to work, both from the standpoint of the fam-

ily and of the factory where he worked. She contacted the St. Vincent de Paul agency and was able to secure a young woman to come in and keep house and wait on the mother and father. The visiting nurse continued to give the actual nursing care. A neighbor was asked to do the laundry which she was glad to do. Thus, the young man was relieved of his home responsibilities and was able to return to his work.

Cause: Illness of another member of the family.

Miss Z. found the M. family panic-stricken. Mrs. M. was very ill with pneumonia. They could get no one to help in the home. The daughters were only 7 and 9 years old. The father was staying home from his work in a defense plant. The physician had contacted five hospitals but there was not a bed available. Then he ordered a graduate nurse on the case but the registry had no one on call and suggested the visiting nurse.

The visiting nurse gave the mother the treatments ordered by the physician. She inquired into the food the family had been eating and feeding the sick mother. It had been sketchy indeed, so she suggested simple nourishing food that could be easily prepared. Leaving the mother sleeping, she went into the living room to talk with the family about the mother's care during her absence. She carefully discussed the possibility of calling on a friend, neighbor or relative to help the husband during his wife's illness.

As Mr. M. sat and collected his thoughts after the excitement of the day, he suddenly snapped his finger and thumb and said, "By George! My wife has a very good friend living right here in the city who is a graduate nurse. She is married, but if she can leave her home, I'm sure she will come and take care of my wife." The visiting nurse waited until Mr. M. returned from telephoning the friend. He came back looking very relieved and said, "She will be here tonight and stay as long as we need her and I can go back to work tomorrow. I want to thank you for coming in and straightening us out so I could think."

War Damaged Ears

By LAURA STOVEL

WINNING the war comes first with every good American. Later on we can count the cost. One big item on the debit side will be damaged ears. Bombardiers subjected to sudden and terrific explosive sounds; pilots, enduring swift changes of atmospheric pressure; workers in war industries, submitting their ears to sharp or incessant noises; and possibly civilians injured by bombs—all these will roll up big debit figures.

Many of the debits can be transferred to the credit side of the war ledger. Doing so is a task that challenges the best in all of us. The change is effected through complex processes summed up in that important word, *rehabilitation*. It is a five syllable word, representing the services of at least five different groups: nurses—particularly public health nurses—physicians, social workers, rehabilitation agents and employers. Mr. John Q. Public can play an important part, too, for he must learn that imperfect hearing is as common as imperfect sight; he must know about lip reading and how to make his own speech clear and intelligible so that he can be understood; he must know that mechanical hearing aids are to the ears what eye glasses are to the eyes, and almost as commonly used and as casually accepted.

ON NURSES rests considerable responsibility, for they may be the very first persons to come into contact with

war deafened veterans. John S. Coulter, M.D. of Chicago, speaking before the Conference on Rehabilitation called by the American Physiotherapy Association in New York last August, said, "*Rehabilitation should start the day a man is injured.*" It was pointed out by other speakers at the same Conference that during and after the last world war there was far too long a lapse between the time of a man's injury and the time his program of rehabilitation began. This was not strange, for it was not until after the war that the Rehabilitation Act, providing for state and federal funds to train or retrain the physically handicapped, was passed. In that interim, men's thoughts and sentiments crystallized. Some of the veterans felt that their war injuries made them wards of the state, that they were entitled to financial support for the rest of their lives. They did not analyze the destructive effect of such thinking on their own characters.

Naturally, nurses and physicians will minister first to the physical needs of war casualties, but almost simultaneously they can minister to the needs of the spirit. A man must not be allowed to think of himself as done for, his career ruined. Nurses can and will acquire the technique of guiding their patients' thoughts along constructive lines. With just the right touch here and there they will help to mold character; with the right information at their tongues' ends they will begin the process of building on what

PUBLIC HEALTH NURSING



A hearing aid clinic where various devices may be tried in an atmosphere free from commercialism

remains. In so doing they will help to prevent war casualties from becoming life-time burdens to themselves and others.

BOTH NURSES and physicians must know what aids a war deafened veteran needs and where and how he may obtain them. First of all, there is lip reading, an art by which persons understand the speaker's thoughts by watching the movement of his lips, the expression of his face and other cues. It would take several volumes to tell all the available true stories of young people getting through college and university with the aid of lip reading and of persons of all ages depending upon it to hold their own in business and social life. Lip reading is taught in societies for the hard of hearing scattered throughout the United States and Canada, in some adult education departments of public schools, by many private teach-

ers, and in a few universities and colleges. Perhaps the nurse can give the patient an idea of what lip reading is, if she will remember to keep a good light on her face while she speaks, use clear, distinct speech, and not expect too much. The patient feels like a stranger in a strange land learning a new language. He must get it step by step.

If a usable part of a person's hearing remains, he can be fitted with a modern hearing aid that will almost put him in the class with the normally hearing; not entirely, but almost, depending on the type and degree of his impairment and the fitting of the instrument. There is need for hearing-aid clinics throughout the country, where the ear handicapped may try various makes of instruments in an atmosphere that is free from commercial influence. It is a time-consuming task to try one device after another, seek-

WAR DAMAGED EARS

ing the one best suited to the individual. There are at least 12 such clinics in this country where service is available. Perhaps one good outcome of this evil war will be the establishment of more clinics for they are needed now and the need will increase. In the meantime, the American Society for the Hard of Hearing, Washington, D.C. gives referrals to such clinics as there are.

MANY NURSES and physicians are already familiar, we are sure, with their local society for the hard of hearing in many of which there is a trained social worker ready to serve. We wish that every local society had at least one trained staff worker, but even where all activities are handled by volunteers, there is an air of friendliness and understanding that often can do much to cure unhappiness and depression. Of the 160 or more societies, 92 own group hearing aids so that lectures and entertainment features can be enjoyed. Eleven own one or more audiometers for testing hearing. Eighty-five provide lip reading practice classes and 63 provide instruction classes. Practically all of them give vocational advice and work in harmony with the state rehabilitation services, referring their clients to these well-equipped agencies. It is because these societies are democratic and anxious to help others that they have succeeded. Their membership is a cross section of the community, both as to age and social status. Members help each other and in so doing help themselves. Henry L. Amonette of the New York State Rehabilitation Division once said, "In affording facilities for social activities, societies for the hard of hearing are the best agencies for the development of personality and contribute directly to the solution of vocational problems. Optimism, cheerfulness and self-confidence are engendered. Frequently

these have contributed more to the ultimate satisfactory adjustment of some of our cases than the program of training."

EVERY STATE in the Union has a state rehabilitation service to which both state and federal governments contribute funds. Looking to the immediate future and realizing the need for greatly expanded service, two bills have been presented to Congress, one providing rehabilitation services for war veterans, the other for disabled citizens. The former bill was passed on March 24. It will be administered by the Administrator of Veterans Affairs. The other bill, to be administered through the United States Office of Education, is now before Congress.

If nurses are well informed about these services they may begin the day a man is injured, or perhaps soon after that, to tell him about them. In so doing they open up vistas of constructive thought and avenues of practical aid. Records of the services are filled with "success stories"—not the stories of great geniuses like Edison and Beethoven, so often named as models for the hard of hearing, but everyday men and women who have been helped to turn stumbling blocks into stepping stones.

Some nurses may not come into very close contact with employers, yet many do and realize their opportunities. The two groups are co-workers. The nurse starts the veteran out on the right road and shows him the doors through which he may enter to find happiness, independence and a sense of being needed. Employers must open the last door, or, rather, they must hold wide the doors that are being opened today; for, with the clamor for more manpower, the physically handicapped are being sought out. Those of the hard of hearing who are well trained and well equipped are providing what is so often claimed for them—

PUBLIC HEALTH NURSING

that they are faithful, anxious to please, have better-than-average powers of concentration, are not disturbed by chatter, are a decided asset to the business.

Today, all mankind is learning to think in terms of the whole, not in terms of small parts or fragments. We are fighting a global war. We know that all nations are interdependent. We are making an all-out effort to win the war. We know that no one branch of the country's defenders can do it alone. We must retain this plan of

thinking in terms of the whole and carry it over to our thinking and planning for individuals. We must think of the whole man—all his needs, his potential abilities, his ultimate attainments. Every group which can contribute to rehabilitation must make an all-out effort to restore war damaged veterans to their rightful places in social and economic life. Public health nurses have a vital part to play in this restoration.

Picture is by courtesy of the Boston Guild for the Hard of Hearing.

Survey of Public Health Nursing Care of the Sick

How do American communities which have no organized resource for nursing care of the sick in their homes fill the gap—or do they fill it? These questions prompted a survey of 16 communities by the National Organization for Public Health Nursing. They are answered in the completed report which is now available. Under the auspices of the Committee on Nursing Administration, results of extensive field observations were studied and certain recommendations common to a majority of the communities surveyed were made.

1. Coordination or amalgamation of nursing services in a manner to bring about unification of effort, economy in the use of public health nursing personnel and facilities, and competent nursing leadership, supervision, and in-service education was urged.

2. The establishment of a community-wide public health nursing committee, with non-professional citizen representation as well as representation from organizations and agencies interested in public health nursing services is essential to their best development. The first and foremost functions of such a committee should be to study nursing needs, and to support and help develop the best type of organization for meeting them.

3. Where, in spite of thorough coordination of services, a lack of public health nursing personnel hinders the development of home nursing services for the sick, understanding of the

need for such services must be sufficiently underspread to ensure that enough local public and private funds will be made available.

4. In communities that are not able to provide the necessary services from local resources, aid should be sought, at least for the duration of the war emergency, from federal and national agencies such as the United States Public Health Service, the Children's Bureau, and the American Red Cross.

5. Wherever a well organized public health agency such as a department of health already exists, the community-wide general public health nursing service, including care of the sick, should become part of such an agency. Where there is no such competent agency, the community-wide nursing service must probably be developed separately through a strong public health nursing committee which is truly representative of the community.

6. The community-wide nursing service, if it is to fulfill its real purpose, should provide all types of service on a pay, part-pay, and free basis.

7. If nursing service is provided under intelligent, capable community leadership and under competent direction, practicing physicians, insurance companies, welfare departments, child-caring agencies, and many other groups will for efficiency and economy purchase services from a common source rather than provide their own.

The Committee on Administrative Practice of the American Public Health Association has endorsed the general findings of the survey and the recommendations.

Duties of Nurses in Industry*

THE industrial expansion occurring throughout the United States and the increasing understanding of the importance of the health of workers made necessary some consideration of the factors influencing the development of an industrial nursing program. For this reason the Public Health Nursing Section of the American Public Health Association at its 1940 Annual Meeting authorized the appointment of a special committee to be known as the Committee to Study the Duties of Nurses in Industry. This committee became active early in 1941 and planned a nation-wide industrial nursing survey. Such a survey was to serve as the basis (1) for determining the range of nursing activities included in all types of industrial nursing services (2) for formulating a statement of recommended practices in industrial nursing and (3) for defining the current problems confronting nurses in industry.

THE PRELIMINARY SURVEY

The committee decided before undertaking a survey on a nation-wide scale to do a preliminary survey. For this purpose a form and accompanying instructions defining the items on the form were prepared. During the summer of 1941 the form was used by committee members in 109 establishments which employed 235 nurses. Whenever possible the general plans for the survey and the practicality of procedures to be followed were discussed with the industrial nurse being interviewed and with the organized group of

industrial nurses in the area, if such a group existed.

The results of the preliminary survey were presented in a progress report to the Public Health Nursing Section at the 1941 Annual Meeting of the American Public Health Association. At this time the Section accepted the several recommendations of the committee. The first recommendation was to continue the survey on a nation-wide scale since the report indicated that such a survey would be of sufficient value to warrant the effort, and the procedures as established seemed to be practical.

The second recommendation provided for the establishment of two committee groups, the Advisory Group, and the Working Group. A third group, the Consultant Group, was decided upon at a later meeting of the committee. The third recommendation authorized the committee to request the Division of Industrial Hygiene, National Institute of Health, U. S. Public Health Service, to guide and direct the survey and to assume the responsibility for the tabulation and analysis of the collected data.

ORGANIZATION OF COMMITTEE GROUPS

The *Advisory Group* was made up of representatives of organized groups of industrial nurses throughout the country. In some areas where the industrial nurses were not organized a well known industrial nurse was invited by the committee to serve on the Advisory Group.

The functions of the Advisory Group were (1) to assist with the planning for and the conduct of the survey and (2) to prepare recommendations of acceptable

*Report of the Committee to Study the Duties of Nurses in Industry of the Public Health Nursing Section of the American Public Health Association.

PUBLIC HEALTH NURSING

practices of industrial nursing based on the survey findings.

The appointment of the Advisory Group stimulated organizations of local industrial nurses' associations and afforded industrial nurses an excellent opportunity to plan for the development of practices in their own field.

The *Working Group* was composed of nurses on staffs of state health departments. The chief function of this group was the collection of data for the survey. In those states where a nursing consultant for industrial hygiene was employed, she was made responsible for collecting the data. In other states, arrangements were made for the staff of the division of public health nursing to accept this responsibility.

Serving on the Working Group afforded the consultants of the several divisions of industrial hygiene of the respective state departments of health an opportunity to become acquainted with the industrial nurses and the problems relating to industrial nursing in their respective districts. Likewise the nurses on the staff of the divisions of public health nursing who participated in the collection of the data acquired more knowledge of and greater interest in industrial nursing.

The *Consultant Group* was made up of representatives of the Council on Industrial Health of the American Medical Association, the American Association of Industrial Physicians and Surgeons, the American Industrial Hygiene Association, and the National Conference of Governmental Industrial Hygienists. Its function was to advise on all matters pertaining to the survey.

COMMITTEE ACTIVITIES

In general, committee and group activities were carried on through correspondence. However, several meetings were held, the first of which was held in November, 1941, and included members of the

Advisory and Working Groups. At this time the form used in the preliminary survey was revised and plans were completed for conducting the survey on a nation-wide scale. Two other meetings were held in April and May, 1942, for the purpose of reviewing the progress made during the first two months of work and discussing problems encountered in collection of the data.

The final meeting of the Advisory Group was held in January, 1943, after the official termination of the activities of the committee as a whole. The group then prepared recommendations on acceptable practices of industrial nursing.

A report of the analysis of the findings of the survey data collected up to October, 1942, was given in a paper read before the Joint Session of the Industrial Hygiene and Food and Nutrition Sections at the 71st Annual Meeting of the American Public Health Association, St. Louis, Mo., October 29, 1942.

By official action of the Public Health Nursing Section, the committee was formally dissolved with the understanding that further study of the data was to be carried on at the National Institute of Health and the final report containing the recommendations to be prepared by the Advisory Group would be published by the Division of Industrial Hygiene, National Institute of Health, U. S. Public Health Service.

RESULTS OF THE SURVEY AND RECOMMENDATIONS OF THE ADVISORY GROUP

NATURE AND SCOPE OF THE SURVEY

The committee was successful in obtaining completed schedules on 924 industrial establishments employing approximately 2,500,000 workers and located in 36 states and the District of Columbia. The information was collected through personal interviews with the plant nurse or other plant official by consultant nurses in the

NURSES IN INDUSTRY

divisions of industrial hygiene, by staff nurses in several state departments of public health nursing, and by committee members. The survey was begun in March, 1942, and continued through December of the same year.

Eighty-four percent of the plants were engaged in manufacturing and included a large number of essential war industries producing aircraft, ships, machinery, ordnance material, and clothing for the armed forces. Federal as well as private industries producing ordnance material were surveyed. The remaining 16 percent of the plants were non-manufacturing industries and included coal mines, metal mines, construction projects, department stores, public utilities, insurance companies, banks, and several service industries.

The plants varied widely in size. Over one half (58 percent) of the industries with full-time nursing services employed from 500 to 2,500 workers. Sixteen percent had less than 500 workers and 26 percent employed more than 2,500 workers.

In general, the aim of the committee was to obtain as much data as possible on industrial establishments maintaining what is known as "nursing service." For this reason three distinct types of nursing service were sampled; namely, in plants in which the nursing activities were carried on by at least one full-time registered graduate nurse; in plants employing a registered graduate nurse on a part-time basis; and in plants in which such activities were carried on solely by non-professional personnel such as practical nurses or first aid attendants. Some of the non-professional personnel had completed Red Cross or Bureau of Mines first aid courses.

The first group of plants, those employing at least one full-time registered graduate nurse, predominated and constituted the chief group for purposes of the survey. Of the 924 plants surveyed, 868 were of this type and employed a total of 3,027

nurses. The National Survey of Registered Nurses showed that in 1941 there were some 6,000 industrial nurses in the country on both active and inactive status. Recent estimates indicate that in 1942 this number probably had increased to 9,000 or 10,000. If this figure is correct, the activities of approximately one third of the registered industrial nurses in the country are covered by the survey.

The other two groups of plants were comparatively small. Twenty-two plants with part-time nursing service were surveyed. In 34 other plants, nursing service was rendered by practical nurses or first aid attendants.

FACTORS INFLUENCING RANGE OF DUTIES

The survey revealed that the duties of industrial nursing personnel ranged from "strictly first aid" to an all inclusive program embracing the present concept of health promotion in industry. Such activities include care and treatment of injured and ill workers, assistance with medical examinations, participation in health education programs, assistance with safety education and accident prevention, assistance with plant sanitation, participation in welfare activities, and home nursing services.

The nurse may be engaged in one or all activities pertinent to such programs. The extent to which she participates is determined not only by the attitude of the management toward health and welfare of employees, the differing occupational needs and health requirements of workers, but also her own professional preparation, vision, and initiative.

When the type of medical service provided in the plant was considered, the analysis indicated that the responsibility delegated to the nurse was greater and her activities were more numerous in industries where the physician was on call than in those plants where the physician served part-time or full-time, particularly

PUBLIC HEALTH NURSING

in the latter case. Physicians served full-time in 23 percent of the plants surveyed, part-time in 37 percent, and on call in 40 percent.

When nurses' activities were correlated with plant size as determined by the number of workers, similar trends were observed but not to the same degree as in the cases of classification by type of medical organization.

Three other factors influencing the duties and responsibilities of the industrial nurse are (1) the provision for written standing orders or written procedures (2) the type and extent of nursing supervision and (3) the relation of the medical department to other departments in the plant organization.

WRITTEN STANDING ORDERS

It is a recognized principle that all nursing care should be given under the direction of a licensed physician. It will be noted that 77 percent of the industrial nurses surveyed were employed in plants where the physician served part-time or on call, and hence it was necessary for the nurse to assume greater responsibilities. Suitable instructions in the form of written standing orders should be provided by the part-time or on call physician to insure satisfactory service during his absence. It is the responsibility of the nurse to secure such orders. Standing orders are a protection to the nurse, to the worker, and to the management.

Written orders outlining the procedures to be followed were provided for nurses in 42 percent of the plants with full-time physicians, in 37 percent of the plants having part-time physicians, and in 30 percent of the plants where the physician is on call. Thirty-six percent of all plants surveyed provided written standing orders for nurses.

Recognizing the serious import of these findings, the Advisory Group made the following recommendations. *Nurses work-*

ing without the direction of a full-time physician should have written standing orders. Where no one physician is responsible for the plant medical service, the nurse may secure standing orders from the committee on industrial health of the county medical society. Further, the nurse working under the direction of a full-time physician should have written procedures for her guidance. In plants where non-professional workers are employed, written standing orders and/or written procedures should be furnished for the guidance of such personnel.*

SUPERVISION

While it was not possible to determine from the data the effect nursing supervision had on the extent or character of the nurse's participation in the plant services, undoubtedly this is a contributing factor. Provision for nursing supervision was reported in 48 percent of the 420 plants employing two or more nurses. After consideration of this factor, the Advisory Group defined supervision as follows:

Supervision is a democratic situation in which a person who has had opportunity to acquire a broad knowledge of her field and has proved her ability offers to share her knowledge and experience with another person in such a way as to help that person to do better work more easily and with greater satisfaction.

Believing in the importance of nursing supervision for industrial nurses, the Advisory Group recommended that *where two or more nurses are employed, one nurse be designated as one of the following, depending upon the size of the nursing staff and the amount of responsibility*

* Suggested written standing orders have been prepared by the Council on Industrial Health of the American Medical Association and have been made available to the component societies for the use of their state and local committees. Several state divisions of industrial hygiene have prepared suggested standing orders which are available to industrial nurses.

NURSES IN INDUSTRY

delegated to her: director of nursing service, nursing supervisor, chief nurse, head nurse, or charge nurse. Further, when the nursing staff of the particular industry is not sufficiently large to warrant the employment of a nursing supervisor, the facilities for advisory service offered by the state department of health or the insurance company should be utilized.

As has been previously pointed out, the character and extent of nursing participation in the industrial health program is dependent upon the nurse's professional knowledge and understanding. One of the ways in which her professional growth and development can be fostered is through membership in professional organizations. Nurses should maintain their professional affiliations and be interested in keeping up with advances in their profession. The affiliations desirable are alumnae, district and state associations and the American Nurses Association, the local industrial nurses groups and the American Association of Industrial Nurses, the state organization for public health nursing, and the National Organization for Public Health Nursing.

RELATION OF MEDICAL DEPARTMENT

The relation of the medical (including nursing) service to other departments within the plant organization has considerable influence on the development of health service. To facilitate the effective operation of the medical department the person in charge should be able to discuss problems with top management. Management should consider its medical department as an asset rather than a luxury, or, as in some instances, a liability. It should be given the status which it merits on a par with operations. It was recommended that *the medical department, regardless of size, should be responsible to an executive of the organization.*

ACTIVITIES

The following summary is based on the analysis of the activities of 3,027 full-time registered graduate nurses employed in 868 establishments, irrespective of plant size or the prevailing type of medical organization. The recommendations concerning each activity were prepared by the Advisory Group.

Nursing care and treatment. Nursing care and treatment of occupational injuries and illnesses and emergency care of non-occupational illnesses was carried on by practically all of the nurses included in the survey. However, there were a few industrial nurses employed for mining and textile mill villages who gave no nursing care and treatment in the plant, but served the workers and their families in the latter's homes.

Hospital nursing may also be a function of the industrial nurse. Thirty-seven establishments operate their own hospitals. In all but two of these, nurses rendered nursing care to hospitalized workers and at times assisted in the plant dispensary.

In plants where a full-time physician is employed, the nurse's responsibility for care and treatment is limited to assisting the physician, or to the care of workers who do not need the attention of the physician. In plants employing a physician part time or on call, the nurse sees all workers who are injured or ill and exercises judgment relative to medical treatment. She may administer the necessary care, give emergency care until the part-time physician makes his regular visit, or refer the worker immediately to a physician or to the hospital.

The importance of the nursing care and treatment phase of industrial nursing is frequently minimized by other professional groups. However, it requires professional competence, skill, and the exercise of judgment, particularly in plants where only part-time or on call medical service is provided.

Assistance with medical examinations. The second major activity of industrial nurses is assistance with medical examinations of workers. Over three fourths, or 82 percent, of the establishments did medical examinations of the workers either as a part of the preplacement or of the employment policy. This large proportion is accounted for by the fact that only those plants with some type of medical program were surveyed.

Practices differed as to where the medical examinations were performed. It was found that nurses assisted in 78 percent of the 464 establishments which provided for medical examinations of workers at the plant, and in 10 percent of the 250 plants which arranged for examinations at the physician's office, the hospital, or at some central clinic.

Although it would seem that a high percentage of the nurses assist with medical examinations, the data indicated that such assistance was frequently limited in extent. In some plants, nurses assisted with many of the following activities: taking the history, recording the findings of the physician, chaperoning female workers, testing vision and hearing acuity, measuring height and weight, taking readings of blood pressure, temperature, pulse and respiration, and taking specimens for serological and other laboratory tests. In other plants nurses performed only one or two of these activities. Apparently more adequate health services in industry could be provided by further utilization of nursing skills.

The nurse's assistance during the medical examination may aid the physician to secure the worker's understanding (1) of the value and use of the medical service and (2) of the value of the examination and the procedure to be followed. In addition, her assistance will conserve the time of the physician.

It was recommended that *nursing assistance in the medical examination, both preplacement and other types, should include the following activities: (1) interviewing the worker previous to the examination (2) doing routine tests and explaining their significance (3) taking specimens for serological and other laboratory examinations and explaining their significance (4) interpreting to the worker plant policies regarding health and welfare and his responsibility for cooperation (5) making periodic inspections for symptoms and indications of occupational diseases and (6) making inspections and interviewing workers in connection with return-to-work permits.*

Nurses were called upon to do the urinalysis in one half of the 370 establishments where physical examinations which required laboratory tests were made in the plant. The examination was usually limited to testing for sugar, albumin, and specific gravity. In nine plants nurses performed the complete function of a laboratory technician and did serological and other indicated tests.

Although a large proportion of the establishments arranged for X-rays of workers when such were indicated, the survey showed that only 170 were equipped with X-ray equipment. In almost one half (48 percent) of these plants the work was done by the plant nurse.

These data show that a fairly large number of nurses were engaged in special technical services not usually included in professional nursing preparation and for which trained technicians could have been secured. It was necessary for the nurse in these cases to learn the several technics before she could successfully perform the duties involved. The volume of work required, the physician's preference, and the attitude of the management toward the employment of technicians are some

of the factors which determine the nurse's participation in these activities.

Since it is frequently necessary for the industrial nurse to do laboratory work, take X-rays, give physiotherapy treatments, make electro-cardiograms and basal metabolic tests, the Advisory Group recommended that *the nurse have special training in the technics of rendering each of these services when they are required of her. However, when the volume of special technical services requires the time of one individual, a technician rather than a nurse should be employed.*

Participation in health education program. Modern concepts of industrial health have perhaps wrought more changes in the field of health education than in any other aspect of the industrial health program. The survey indicated that nurses did very little health education work. However, the incompleteness of records and reports concerning such services rendered by the nurses prevented collection of reliable data on this activity.

Informal counseling with workers during the course of treatment, the distribution of health literature, and the follow-up of remediable physical defects were some of the specific ways in which nurses were participating in health education.

Organized health education programs were carried on in less than 20 percent of the plants. These embrace preventive as well as promotional activities in the control of tuberculosis, syphilis, colds, and occupational diseases, and in the field of dental hygiene, mental hygiene, fatigue, and rehabilitation of the worker.

It is generally conceded that an industrial nurse has almost unlimited opportunity for health education and health supervision of industrial workers. The extent to which she takes advantage of this opportunity depends on her ability and understanding as well as on plant policies.

Also in industries where a high occupational injury rate exists the volume of treatments may prevent the nurse from utilizing the opportunities for health education. Further, since the medical examination records are not available to the nurse in many plants, this obviously limits the amount and quality of health instruction she can give workers. Finally, a planned program for health education and supervision of workers comparable to the safety education and accident prevention program in force in many plants is essential if the nurse's participation is to be effective.

Conservation of the health of industrial workers in order to improve efficiency and lessen absenteeism is recognized as vital to production. Therefore, the Advisory Group recommended that *the nurse's participation in the plant health education program be extended and improved. Such a program should include definite plans for: (1) follow-up for correction of remediable conditions (2) supervision and rehabilitation of workers with adverse health conditions (3) maintenance of complete records showing care given for non-occupational conditions (4) health teaching in the training program (5) utilization of community resources including private physicians, health and welfare agencies.*

Another health education activity is the teaching of formal classes. One hundred and ten nurses indicated that they taught regularly scheduled classes in home nursing, standard or advanced first aid. Frequently, not only workers but also their families enrolled in these classes.

Home nursing classes afford the woman worker an opportunity to improve her knowledge of general health and to gain an understanding of methods of caring for sick members of her family. First aid instruction makes the worker more safety

PUBLIC HEALTH NURSING

conscious. It was recommended that *nurses in industry take the necessary steps to become authorized Red Cross home nursing and first aid instructors.*

Assistance with safety education and accident prevention. Although at times the nurse's conception of the extent of her activities in health education and promotion among workers was vague, usually little doubt existed concerning her part in the safety activities of the plant. In some cases she had complete responsibility for such activities; in other cases her duties were limited to the preparation of reports on accidents and to attendance at meetings. In 34 percent of the 674 establishments which have organized safety committees, nurses participated as members. In fact, two of the nurses were safety committee chairmen, and 24 were secretaries. In another 5 percent, nurses reported that, although not members, they attended meetings and often gave talks on safety education.

Nurses assisted actively in plant accident investigations in 41 percent of the plants. They went to the scene of the accident, interviewed witnesses, and conferred with the foreman concerning recommendations for prevention of similar accidents. Fifty nurses reported voluntarily that they were responsible for the purchase, distribution, and maintenance of goggles, safety shoes, respirators, uniforms and similar protective equipment.

The amount and character of the nurse's assistance with the safety education and accident prevention program is due in a large measure to the fact that provision is made through plant policy for such a program and that state laws and insurance company practices require adequate and complete records of compensable occupational disabilities.

It is recognized that many of the services now being rendered by nurses are not essentially nursing. However, the contri-

bution which industrial nurses can make to the reduction in the rate and severity of accidents should not be minimized. Therefore, the Advisory Group recommended that *the nurse should not be responsible for the planning or direction of the safety program but that she assist in the following activities: (1) proper placement of workers according to physical and mental fitness (2) teaching the training course (3) safety committee work (4) record and report keeping (5) individual instruction of workers regarding accident prevention (6) visual education, movies, posters, and printed material and (7) distribution and care of protective equipment.*

Assistance with plant sanitation. In industries where sanitary engineers are employed, the responsibility of the nurse is limited to the assistance of sanitary inspections of toilet, wash, rest, and change room facilities for women workers. Nurses in 9 percent of the establishments surveyed performed this duty. In another 23 percent, they also assisted with inspections of ventilation, lighting, and house-keeping facilities. Nurses assumed the complete responsibility for routine plant inspections in 5 percent of the establishments. Many nurses reported voluntarily that they were responsible for the supervision of matrons when such were employed, and likewise for the cleaning force.

It was recommended that *the nurse show an active interest in all phases of plant environment that affect the health and morale of the worker. However, direct responsibility for the supervision of plant sanitation should be delegated to other departments whenever possible.*

Participation in welfare activities. In general, the workers avail themselves of the opportunity to discuss their financial, marital, religious, and other home troubles with the plant nurse. Many plants pro-

NURSES IN INDUSTRY

vide a special department to handle the worker welfare activities. In such plants the nurse refers the problems to that department for further action. Otherwise, she may assume complete responsibility for welfare activities.

In addition, nurses indicated that they were responsible for the inspections of the cafeterias in 43 plants, and gave dietary advice to cafeteria managers in 13. The nurses managed the cafeteria or lunchroom in 8 plants, including the hiring and firing of workers, planning menus, and ordering of supplies.

Welfare activities in a plant are recognized as contributing to the morale and efficiency of the worker. Therefore, it was recommended by the Advisory Group that *nurses participate in and promote welfare activities. The nurse's participation may include: (1) development of group sick benefits, hospitalization, and life insurance plans (2) personal counseling with workers regarding welfare problems (3) development of recreation program (4) cooperation with local welfare agencies (5) planning of cafeteria, lunch rooms and canteen services.*

Home nursing service. In 21 percent of the establishments surveyed, nurses made at least 5 home visits a month, in addition to performing their duties in the dispensary. Additional nurses were employed for home visiting in 6 percent of the plants. Among the reasons for making home visits are: (1) to give health supervision (2) to determine eligibility for benefits (3) to ascertain causes of absence (4) to assist the worker with his social problems and (5), less frequently, to give nursing care to the ill or injured worker. A few other establishments have arrangements with the local nursing associations or contracts with insurance companies for home visits. Three of the reasons for which visits are made to the homes of workers, namely, those to determine

eligibility for benefits, to ascertain cause of absence, and to assist the worker with social problems, do not require the skills characteristic of nursing but may be essential to the service.

Home nursing care for injured and ill workers aids in the promotion of the general health, reduces absenteeism, and contributes to the morale of workers. The data indicated that this service is seldom rendered by plant nurses. However, when home visits are made by the staff of a nursing association, either through provisions of group insurance or arrangements between the plant and the association, the primary purpose for making the visit is to give nursing care.

Several factors make it more desirable for an industry to enter into a contract with a local visiting nurse association rather than to employ a nurse for home service. The travel time necessary for a nurse to make a special trip to the home of a worker who is commuting from a great distance makes the cost of such visits in time and money impracticable. In this connection the recognition on the part of industrialists of the need to avoid duplication of service—duplication of activities performed by a community agency in which they as responsible citizens of the community are interested—is of great importance. When this factor is fully appreciated, industry will recognize the advantage of having the community nurse serve the plant for all home visiting, inasmuch as she may already be serving the family, and therefore is in a position to contribute her knowledge of family health problems to the industrial medical department.

After review of the data the Advisory Group recommended that *home nursing service be provided by the plant. The plan for visiting sick or injured workers in their homes should be developed to secure maximum benefits to the workers and*

PUBLIC HEALTH NURSING

to the plant. Employment of nurses for this service may be necessary where community resources are not available or cannot be coordinated with company policy.

Records and reports. Another important function of the nurse is completing and filing records and preparing reports of first aid activities. All nurses keep records of treatments. Some are complete and others quite sketchy, depending on the requirements of the management and the nurse's own knowledge of such matters. The analysis revealed that nurses were given clerical assistance with their records and reports in 35 percent of the establishments. Medical departments in the larger plants are usually staffed with full-time clerks and stenographers, relieving the nurse completely of this responsibility.

In 65 percent of the establishments nurses were required to submit periodic reports on activities of the plant dispensary to the management or to the physician in charge. In 56 percent of the plants nurses assisted with workmen's compensation reports.

Records and reports are to the industrial nurse what bookkeeping is to the accountant. They make it possible for her to prove to management the desirability of and the value derived from industrial nursing service.

It was recommended that: (1) *the medical records be kept strictly confidential except as interpretations of them are needed by management* (2) *all medical records be kept in the medical department and available for use each time a worker presents himself for care* (3) *when the physical examinations of workers are made outside the plant, the records or copies thereof be made available to the nurse* (4) *clerical assistance be provided in order that the nurse's time may be conserved and records adequate.* Further, *the following types of records and reports*

are needed: (1) daily record or log (2) individual record including the medical examination, clinical visits, and the correction of remediable conditions (3) disability absentee records (4) compensation records and reports and (5) monthly and annual reports to management.

CURRENT PROBLEMS OF INDUSTRIAL NURSING

One of the objectives which the committee hoped to achieve through the survey was some insight into current problems of industrial nursing. However, when the original plans for the survey were made, the committee did not anticipate the war and the accompanying demands for nursing service which we are witnessing today.

The extent to which nursing services in industry have expanded is revealed strikingly by the survey. Of the 2,450 full-time registered nurses for which data were available, 40 percent began their employment in 1942. Between January 1940, and December 1942, more than two thirds, or 70 percent, of the nurses began their employment. Thirty percent were on their present jobs prior to 1940.

Thirteen percent of the 850 plants for which data were available established nursing services for the first time in 1942. Thirty percent of the services were established during the last three years. It is interesting to note that only 7 percent of the remaining plants established nursing services prior to 1915.

As a result of the unprecedented demand for graduate registered nurses in industry, numerous questions have arisen: What professional channels, if any, are utilized in the selection of these nurses? What qualifications are required? On what basis is salary determined? Are they employed to render services essential to the maintenance of the industrial health program? Is the nurse's time conserved wherever possible? What is the desirable

NURSES IN INDUSTRY

number of nurses per unit of employees? Could a part-time nursing service meet the needs of the plant?

SOURCE OF SUPPLY

In the past many employers have not been aware of the professional channels through which nurses might be secured for positions in industry. Various sources have been used with the result that frequently the selection of the nurse has been made without giving proper consideration to duties and responsibilities of the position.

The Advisory Group recommended that *nurses for industry be obtained through professional nursing channels such as: (1) registries approved by local or state nurses' associations (2) Nurse Placement Service* (3) schools of nursing and universities offering courses in industrial hygiene (4) insurance companies and (5) divisions of industrial hygiene in state departments of health.* It was further recommended that *the local industrial nurses group act in an advisory capacity to the above organizations in regard to the needs of industry and nurses who are available.*

QUALIFICATIONS

In order to assist management and others interested in the employment of industrial nurses, desirable qualifications were enumerated by the Advisory Group as follows:

A. Personal

1. An interest in, and an ability to work effectively with, all types of people
2. Good physical health
3. Emotional stability
4. Initiative and good judgment
5. Resourcefulness
6. Ability to organize, especially where nursing supervision is not provided
7. Ability to appreciate the importance of one worker's health to the efficient operation of the industry as a whole

* 8 South Michigan Avenue, Chicago, Ill.

B. Academic

1. High school graduation
2. Advanced education on a college level—desirable
3. Ability to type for the purpose of record keeping—desirable

C. Professional

1. Graduation from an accredited school of nursing connected with a hospital which had a daily average of 100 patients or affiliations with other schools of nursing which provide a broad clinical experience in medical, surgical, obstetrical and pediatric nursing
2. Registration in the state of employment in accordance with the Nurse Practice Act
3. Postgraduate study in industrial nursing with public health aspects—desirable

D. Experience

Experience in hospital emergency room, outpatient surgical department, industrial clinic, and public health nursing—desirable

It was recommended that *industrial nursing organizations make an effort to encourage the employment of nurses who have had the industrial nursing preparation which is available at the present time.*

SALARY

It seems logical to expect that the basis for salary (or compensation) should be the same as that for supervisors of departments, according to the responsibilities involved and the qualifications and experience which are required. The Advisory Group recommended that *a job analysis be made to depict the responsibilities involved in the particular position and that the salary be commensurate with these responsibilities.*

ESSENTIAL SERVICES IN INDUSTRY

The National Nursing Council for War Service recommends** that industrial nurses who are not essential for maintaining minimum health services should serve with the armed forces.

**Priorities for Nurses. National Nursing Council for War Service, 1790 Broadway, New York, N. Y.

PUBLIC HEALTH NURSING

It is considered that the industrial nurses who are essential for maintaining minimum health services are:

1. The nurses who have established health programs in essential industries
2. The nurses who are holding administrative or supervisory positions in the medical departments of essential industries
3. The nurses who have special skills or preparation essential to the maintenance of medical departments

In accordance with this policy the Advisory Group recommended that *staff nurses who are eligible for military service and who may be replaced by nurses not eligible for such duty should be encouraged to enroll for service with the armed forces and should be granted military leave.*

NON-PROFESSIONAL CLINIC ASSISTANTS

In keeping with the national effort to conserve nurse-power during the war emergency, it was recommended that *non-professional clinic assistants be employed in so far as possible, and that the following duties be assigned to them: (1) securing of specimens and care of specimen bottles (2) filling of hot water bottles and ice bags (3) bed making (4) sterilization of instruments and supplies (5) assistance with dressings (6) making surgical supplies (7) care of change rooms, rest rooms and toilets (8) training of matrons.* It was further recommended that *there be written instructions governing the activities of the non-professional clinic assistants and that such assistants be supervised by the nurse.*

DUTIES OUTSIDE THE MEDICAL DEPARTMENT

The analysis revealed that the activities of nurses are not necessarily confined to the medical department. They range from selling telephone slugs and defense bonds to delivering babies. Nurses act as receptionists, relieve in the canteen or at the switchboard. They attend funerals

and weddings, and write letters of congratulations and condolences. Nurses in 91 plants reported that they assist with the clerical and secretarial work in other departments of the plant, figure out wage rates and make out and distribute pay checks. In 30 plants they engage actively in personnel work, hire and fire employees, and keep worker employment records. In 25 plants nurses fingerprint and photograph employees and give identification badges.

In many instances when a nursing service is being initiated by industry the nurse combines with her nursing functions various duties unrelated to health services. Since it has been demonstrated that a plant employing as few as 100 workers can profitably employ a nurse full time, it was recommended that *the nurse's activities be limited to those of the medical department.*

NUMBER OF NURSES PER UNIT OF EMPLOYEES

The number of nurses employed should depend on the type of industry and the number of workers. For the maintenance of complete health service in an industry it was recommended that *there be 1 nurse for up to 300 employees, 2 or more nurses for up to 600 employees, and 3 or more nurses up to 1,000 employees, 1 nurse for each additional 1,000 employees up to 5,000, and 1 nurse per each additional 2,000 employees.* Additional nurses may be required because of hazards present in a particular plant and to supply service for second and third shifts. This number will be reduced in inverse ratio to the number of technical and non-professional workers employed in the medical department. Smaller industries (those employing less than 500 workers) which do not have serious occupational hazards may find part-time nursing services adequate.

NURSES IN INDUSTRY

PART-TIME NURSING SERVICES FOR SMALL INDUSTRIES

Comparatively few employers have felt that full-time nursing service for less than 500 employees is a sound investment. It is being realized to an increasing extent that the number of employees cannot be used as a criterion of the need for an industrial health program. Rather the hazards associated with the working environment and the health problems of the employees are the deciding factors. Effective part-time nursing services have been developed in some cities to meet the needs of the smaller industries through utilization of community nursing agencies or through several plants sharing the services of one nurse. Frequently such part-time service has demonstrated the extent of service needed. In some instances the part-time service has consequently developed into a full-time service, and in other instances the part-time service has been adequate to meet the needs of the plant.

It was recommended that *the use of part-time nursing service should be extended, particularly in plants employing less than 100 workers. It was further recommended that local industrial nursing organizations cooperate with the state industrial hygiene divisions in giving guidance to individuals or agencies which may be utilized in providing such services.*

SUMMARY

The above report of the nation-wide survey conducted by the Committee to Study the Duties of Nurses in Industry serves as an initial attempt to define industrial nursing. Data concerning the nursing service were obtained from 924 industrial establishments employing approximately 2,500,000 workers and located in 36 states and the District of Columbia.

Of the 924 plants, 868, or 94 percent,

employed one or more full-time graduate registered nurses. A total of 3,027 nurses, or about one third of the registered industrial nurses in the country, were at work in these establishments. Twenty-two of the remaining plants employed nurses part time, and 34 utilized only practical nurses or first aid attendants.

Duties of the full-time nurses were classified into eight general groups: (1) nursing care and treatment of occupational injuries and illnesses and emergency care of non-occupational illnesses (2) assistance with medical examination of workers (3) participation in the health education program (4) assistance with safety education and accident prevention (5) assistance with plant sanitation (6) participation in plant welfare programs (7) home nursing service and (8) records and reports. While these classifications serve in a general manner to delineate industrial nursing, a true definition of the profession will not be possible until further standardization of duties is achieved.

Recommendations of acceptable practices in industrial nursing have been made by the Advisory Group of industrial nurses appointed to consider the reported data in light of their own knowledge and experience in this special field. Briefly, the major recommendations are as follows:

1. A nurse working under the direction of a full-time physician should have written procedures for her guidance. All other nurses should have written standing orders.
2. Where two or more nurses are employed, one nurse should be designated as in charge.
3. The medical department, regardless of size, should be responsible to an executive of the industrial establishment.
4. Nursing assistance in the medical examination, both preplacement and other types, should include six specific activities. (See p. 388.)
5. When the volume of special technical services requires the time of one individual, a technician rather than a nurse should be employed.

PUBLIC HEALTH NURSING

6. The nurse's participation in the plant health education program should be extended and improved. (See p. 389.)
7. Nurses should take steps to become authorized Red Cross Home Nursing and First Aid instructors.
8. The nurse should not be responsible for the planning or direction of the safety program but should assist in seven specific activities. (See p. 390.)
9. The nurse should show an active interest in all phases of plant environment that affect the health and morale of the worker, but direct responsibility for the supervision of plant sanitation should be delegated to other departments whenever possible.
10. Nurses should participate in and promote worker welfare activities, especially in relation to five particular services. (See p. 391.)
11. Home nursing service for workers should be provided by the plant.
12. Records and reports are to the industrial nurse what bookkeeping is to the accountant, and an efficient system should be maintained. (See p. 392.)
1. Nurses for industry should be obtained through professional nursing channels only. (See p. 393.)
2. A job analysis should be made to depict the responsibilities involved in a particular industrial nursing position, and a salary should be set for the position commensurate with these responsibilities.
3. Staff nurses who are eligible for military service and who may be replaced by nurses not eligible for such duty should be encouraged to enroll for service with the armed forces and should be granted military leave.
4. Non-professional clinic assistants should be employed, in so far as possible, to conserve nurse-power in performing eight specific duties. (See p. 394.)
5. One nurse should be employed for up to 300 workers; 2 or more nurses for up to 600 employees; 3 or more for up to 1,000 employees; 1 nurse for each additional thousand employees up to 5,000, and 1 nurse for each additional 2,000. Other nurses may be required because of hazards present in a particular plant and to supply service for second and third shifts.
6. The use of part-time nursing service should be extended, particularly in plants employing less than 100 workers.
7. The local industrial nurses' organization should act in an advisory capacity to other professional groups and to state industrial hygiene divisions in regard to the needs in a local industry and the services of the nurses employed therein.

The chief problems in the field of industrial nursing today have been brought about by the very rapid expansion of this service and the marked increase in the number of nurses employed in various war industries. Of the 2,450 full-time registered nurses who supplied the information, more than two thirds, or 70 per cent, began their employment between January 1940, and December 1942. The lack of standardization already existing in this branch of the nursing profession, coupled with this increase in the number of nurses employed without previous experience or preparation, places a heavy responsibility on the comparatively small number of nurses practicing in industry.

The Advisory Group, recognizing the serious import of these problems, has made recommendations which it is believed will promote the best interests of industrial nursing. The major recommendations may be briefly stated as follows:

Incidental to the collection of the survey data, certain benefits accrued to the participating groups. The Working Group responsible for gathering the data acquired more knowledge of and interest in this field. Industrial nursing organization was furthered. Also, the nurses most vitally concerned with the development of industrial nursing were afforded an opportunity to plan for and promote their specialty through serving on the Advisory Group.

NOTE: The committee acknowledges with appreciation the work of Victoria Trasko, Assistant Statistician, National Institute of Health, U. S. Public Health Service, in doing the statistical analyses.

NURSES IN INDUSTRY

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PUBLIC HEALTH NURSING

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Public Health Nursing Observation in the Pre-Clinical Period

By RUTH E. ROBERTS, R.N.

IN CONNECTION with the course, "Social Aspects of Nursing Care," given early in the first year of study at a nearby school of nursing, the student nurse is given an opportunity to gain concrete and vital experience through home observations. These home observations are arranged through our local visiting nurse association.

The aims of public health observation as agreed upon with the school of nursing are:

1. To furnish real experience to the student by enabling her to see the nursing care of ill patients in home situations in connection with the sociological theory which is being studied. Such participation in an experience reinforces theory.
2. To interpret to the student the implications of the social conditions seen.
3. To interpret to the student the work of some of the community agencies. This can be done only to a limited extent, but if the student can early gain the concept that there are agencies to use, she will remember to ask herself when faced with a hospital patient's problem, "Is there in the community an agency to assist with this?"
4. To furnish some information as to the way agencies may interrelate their activities and cooperate in the care of patients.

PLAN FOR OBSERVATION

The student is expected to telephone

the visiting nurse association to make arrangements for the observation experience. This teaches her to "learn by doing" how to contact an agency, make a request and conclude a plan.

The student reports to the visiting nurse association at 9 a.m. The supervisor greets and introduces her to the public health nurse on the staff with whom she is to observe. The supervisor, the nurse and student now discuss the day's cases in relation to these factors: (1) the area the patient lives in (2) why we are visiting the patient (3) how the service is made possible. It is not planned to choose any particular cases, but to see that the student remains in the field long enough to receive a varied experience.

The number of field visits made is governed by the conviction that too many visits may confuse and overwhelm the student. Hence visiting is continued only until several kinds of situations have been observed. The length of time in the district varies, but most students are ready to return to the office by the middle of the afternoon or earlier.

TEACHING RESPONSIBILITY OF THE STAFF NURSE

What does the staff nurse teach? Since we want the student to do the learning she is encouraged to assume the responsibility for asking questions of the staff nurse. In answering, the staff nurse

PUBLIC HEALTH NURSING

can point up the social significances implicit in the query. The student is encouraged to see meanings in the conversation between staff nurse and patient. If these escape her attention the staff nurse can say, "What did you think about Mrs. A's asking about placing her child in a nursery school so she could get a job?" If there is a good response, the staff nurse helps the student understand the problems involved for this particular family.

POST-FIELD VISIT CONFERENCES

When the student returns to the office, it is suggested that a short time be devoted to writing a report of her experience while it is still fresh in her mind.

At 4 p.m. the supervisor or a delegated staff nurse discusses these reports with the students. The supervisor tries to broaden out what the student has observed in the way of family problems and situations to embrace the larger aspects of community problems and situations. She asks such questions as these: Could the illness have been prevented? Was it costly to the community? What was the environmental situation of the family? What does this mean to the health of the community? What adjustments did this cause in nursing care? What use of agencies did you see? What values do you see in them?

The educational director of the school of nursing is responsible for helping the student follow through what she has learned in her observations with the visiting nursing association by individual conferences and class discussion and particularly by having the hospital staff help

the student apply her learning in the hospital situation. Follow-up activities include: referral to agencies; use of the social service exchange; finding out about home environment and personal problems as an aid to better, more understanding nursing service; acquiring a knowledge of community problems, making for future responsible citizens, civically conscious and conscientious.

THE WRITTEN REPORT

It is felt that the student may better write her report spontaneously, rather than follow a prescribed guide. In this way, the supervisor is helped to determine what the student has derived from her observations.

After the educational director in the school of nursing completes her conferences the report may be sent back to the visiting nurse association.

The staff nurse and supervisor can use the report to evaluate what they themselves have contributed to the teaching-learning experience. The staff nurse can append notes regarding the attitudes displayed by the student, and return them to the school of nursing. For instance, the question of housing might elicit such attitudes as disgust at filthy conditions, insight into the responsibility of the community for housing, or appreciation of health hazards implicit in poor housing.

If the student comes to the nursing association for a more protracted affiliation, these papers can again be reviewed. They will aid the staff of the nursing association to promote the professional growth of the student.

A Supervisory Schedule

BY MILDRED TUTTLE, R.N.

A DEFINITE and yet flexible plan for the supervisor's time was the result of experimentation and staff discussion. Appointments were scheduled by the nurse at a day and hour convenient to her. The supervisor and staff nurse both kept the conference appointments, unless arrangements were made to postpone or change the time to meet the convenience of one or the other. Each member of staff was scheduled for the same minimum number of conference hours, thus preventing one member of staff from thinking that another member was being given more time and attention than herself. The plan evolved after many months of thinking and discussing and it has been a decided help to the nursing supervisor and her staff. It was put into effect after having the understanding and approval of the county health officer and the nursing staff. It has done several things:

1. There was more time for supervisor to plan her work.

2. Fewer casual and irrelevant conferences or "visits" on part of staff nurses occurred.

3. Staff nurse and supervisor had time to think through items to be discussed at conference time and could plan ahead. Both prepared for the conference. The supervisor and staff nurse saved up questions and problems until conference time, thus saving time for each other. It should be noted that immediate questions and problems of emergency nature could

be brought up at any time either by the supervisor or staff nurse. This was generally understood by all.

4. Staff nurses, knowing how the supervisor's time was planned by day and week, were much more considerate of her time. The supervisor felt more satisfied with the plan because it represented better organization and administration and she was able to keep an even distribution of time in relation to each nurse. There are on every staff some nurses who tend to take a great deal of a supervisor's time, there are others who tend to take too little. Thus this problem was solved and the supervisor was able to keep in closer touch with each member of the staff.

5. Extra time was always given on the basis of individual need. This was true for both office conferences and field visiting.

6. Since the importance of conference and field visiting had been discussed in group meetings there was complete acceptance of the plan on the part of staff.

7. Since much time has been saved and more work actually accomplished we did not have to justify to the county health director "time spent in the office" and "supervisor's time in the field."

8. The county health director, understanding how carefully the supervisor has her time scheduled, plans his conference with her for Saturday mornings unless there is an emergency situation needing attention.

PUBLIC HEALTH NURSING

WEEKLY SUPERVISORY SCHEDULE

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
9:00		Miss B. (office conference)	Miss D. (office conference)	Miss F. (office conference)	Miss H. (office conference)	Saturday mornings are left free for special conferences. The health department office closes Saturday noon. Emergency calls are taken by the director at his home.
9:30						
10:00						
10:30	Miss A. (office conference)	Miss C. (office conference)	Miss E. (office conference)	Miss G. (office conference)	Miss I. (office conference)	
11:00						
11:30						
12:00						
12:30						
1:00	Miss A. (supervisory field visits)	Supervisor's time for writing up summary of visits in field with Miss A.	Miss B. (supervisory field visits)	Supervisor's time for writing up summary of field visits with Miss B.	Miss C. (Supervisory field visits)	
1:30						
2:00						
2:30						
3:00		Prepares for follow-up conference with Miss A.				
3:30						
4:00		Reviews Miss A's records.		Reviews Miss B's records.		
4:30						
5:00						
5:30						

1st week in month, p.m.—A-B-C, field visiting with nurse.

2nd week in month, p.m.—D-E-F, field visiting with nurse.

3rd week in month, p.m.—G-H-I, field visiting with nurse.

4th week in month leaves supervisor free for preparation of special reports and assignments.

SUPERVISORY SCHEDULE

9. The plan had also made it possible for the supervisor to get most of her work done during working hours thereby reducing the amount of home work in the evening.

10. Each supervisor has one long week-end a month.

11. After 18 months' experience, a new supervisor in this district states:











"This is a good plan and it is still working with these exceptions—conferences are scheduled for one hour, I make field visits in the morning changing conference time as necessary for this."

CLOTHES RATIONING IN GREAT BRITAIN

ALTHOUGH there is today no general sign of an extravagant use of coupons, to make certain there is enough essential clothing at prices most people can afford, 70 to 80 percent of clothes in Great Britain today are utility clothes made from durable and economical standardized cloth in a limited variety of styles. Each adult is allowed 60 coupons for clothing and shoes over a period of 15 months. With these coupons a woman can buy one woolen dress (11 coupons), one sweater (8), two pairs of shoes (5 a pair), five pairs of stockings (3 a pair), and two suits of pajamas (8 each). A man can buy one suit (26), one set of woolen underwear (10), one shirt (5), one pair of shoes (7) and four pairs of woolen socks (3 each). Hats are not rationed. Extra allowances are made for expectant mothers, growing children and certain industrial and agricultural workers. Nurses and other people for whom uniforms are essential must give up some coupons for their uniforms but on a reduced scale, depending on the wear and tear saved on their ordinary clothes.

Less than one half the total clothes and two thirds the number of shoes are available to the British public than before the war. They now buy for durability and are willing to pay more for better quality. Both men and women buy outer clothes rather than underwear. The average yearly expenditure of a family of four on clothes today is \$120 or \$30 per person—last year it was \$40 to \$44 per person and in peacetime, \$80. Children of 14 to 16 years are the biggest users of coupons and require all of the supplementary coupons for their own needs. The British Information Service in the United States, which is the source of this information, states that to give just one more coupon to each person would mean drawing

Examples of how Clothes Rationing has affected the purchasing power of the women of Britain

Average number of articles bought per person per year	
PRE-WAR	NOW
<i>Dresses</i> 	<i>Dresses</i> 
<i>Blouses & Jumpers</i> 	<i>Blouses & Jumpers</i> 
<i>Aprons & Overalls</i> 	<i>Aprons & Overalls</i> 
<i>Stockings</i> 	<i>Stockings</i> 
<i>Footwear</i> 	<i>Footwear</i> 

8,000 workers away from war industries for the manufacture of civilian clothing.

Evaluation of Supervision

By MARGARET E. MAHIN, R.N.

THIS OUTLINE for evaluation of supervision attempts to place on paper a method for estimating a nurse's reaction to supervision in public health nursing. Although it was formulated tentatively only for discussion in a class of graduate public health nurses—supervisors, county and staff nurses—I later put it into its present form because of the expressed need for it. It is hoped that it will stimulate discussion of the evaluation of supervision. Or it might provide a point of departure for others whose thinking is proceeding in the same direction. It might be used as a guide in self-evaluation, or purely as teaching material.

The consensus of opinion of the class was that such a device is one to be used only by supervisors whose personal growth and training of their staffs is such that it would be handled with understanding, integrity and thoughtfulness.

The evaluation of the home visit from the standpoint of supervision might be made in conjunction with the nurse's own evaluation of her home visits. It was the feeling of the class that this part of the material might be used repeatedly, and for purposes of comparison, both of the quality of supervision and of the nurse's growth in ability to profit by supervision. It might incidentally vitalize the whole process.

The remainder of the material, most of the class agreed, could be used to advantage perhaps once only in any one nurse's life on the staff—perhaps after

a year's experience. The time would be determined by individual circumstances.

The class did not agree as to who should see the evaluation—the supervisor on whom it was written, the director, or all persons involved. I myself believe it would lose its value if not at some time discussed face to face by the nurse and the supervisor.

This outline ought to serve a purpose at least twofold: (1) it ought to help your supervisor in her constant exercise of the functions of self-evaluation and self-improvement (2) it ought to help you in self-analysis and your own growth processes as a staff nurse.

Please remember that the following suggestions set down here are meant to be only that—enlarge upon these or upon ones of your own as you wish.

Professional

Is she (your supervisor) well informed on professional developments?

Is she generous of her knowledge, without thrusting it upon you?

Administrative

Is she able to organize her own work so that she never (well, hardly ever) seems hurried?

Is her division of labor equable and flexible?

Is she economical of your time and her own?

Is she willing to plan with you?

Community Relations

Does she know her area of work?

District—nationality groups, economic situation and problems

Community agencies—policies, personnel

Does she know her own agency policies and have the ability to present them in such a way as to make them real and vivid to the lay public, to board and committee members?

Does she have good relationships with doctors

EVALUATION OF SUPERVISION

professional workers and others in the community?

Home Visiting

Preparation:

Does she (the supervisor) plan with you regarding time for home visiting, so that you are able to organize your work to the advantage of patients, supervisor and self?

Does she make it a point to be familiar with your records—social history, medical information, your role in the situation?

Nursing Care:

Does her nursing care set a standard you are glad to try to match? Does it go beyond, or fall short of office demonstration?

If she is observing you, does her presence help you to do your best? Does she allow you and the patient to set the key of the visit? Does she assist you, taking her direction from you?

If demonstrating procedure, does she do so unobtrusively? Include you?

Teaching:

Does she recognize teaching opportunities that you might have missed? Does she use them in a way to strengthen your position in the family? Or to detract from your prestige and usefulness?

Over a period of time, can you see her teaching reflected in family response?

Do you feel that she is willing to learn from sharing experiences with you?

Are you glad to have her on a visit? On a day's visits?

Teaching

Does her presentation of new material seem simple, clear and reasonable? Routine? Confusing?

Do you leave a conference with her frustrated? Stimulated?

Have you received new information timed to your need? By costly trial and error? Only when you asked for it? Not at all?

Personal

Are you at ease with her in discussing professional problems?

In conference, does she make it easy for you to express yourself? Help you to keep your expression on a considered and professional level? Draw you out in such a way that you wish afterward you had said less?

If you were in personal difficulty, would it occur to you to talk to her? Would you then expect to receive advice? Impartial judgment? A sympathetic hearing? Assistance in understanding your problem? Additional information?

Is she sensitive and understanding of other's feelings and viewpoints?

Is she, herself, a well-adjusted person? Can you depend on her mood? Is she friendly and impartial to all her associates? Do you trust her judgment? Her fairness?

If you saw her in a gathering of other community representatives of comparable station, is her appearance and general bearing such that you would be satisfied and proud to have her represent your profession?

THE AMERICAN JOURNAL OF NURSING FOR JULY

S.O.S. from Norfolk, Virginia.....	Dorothy Deming, R.N.
The Treatment of Hernia.....	E. Vernon Mastin, M.D.
Adventures in Civilian Defense.....	Virginia L. Wilson, R.N.
Nitrogen Mustard Gas.....	Alden H. Waitt, A.U.S.
War Challenges Professional Effort.....	Stella Goostray, R.N.
Tea in England.....	Marjorie Peto, R.N., A.N.C.
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Wartime Stresses and Neuropsychiatry.....	Malcolm H. Farrell, M.C. and Kathleena H. Atto, A.N.C.
Rapid Treatment Centers.....	Donna Pearce, R.N.

What the Industrial Nurse Needs to Know about Hand and Foot Injuries

By FREDERICK W. SLOBE, M.D.

WITH WOUNDS of the hands and feet the same principles apply as in the treatment of wounds in any other part of the body. The nurse should use her influence to see that all wounds are sent immediately to the medical department. Every wound is contaminated by bacteria, and it usually takes six hours or so for these bacteria to multiply sufficiently and to burrow deeply enough into the tissues to the extent that they cause an infection.

Each hour of delay therefore increases the likelihood of infection. Hence, the emphatic rule, "The patient must be treated at once!" After six hours the bacteria can no longer be removed by cleansing as they have penetrated too deeply into the tissues. This initial cleansing should consist of a thorough, but gentle, scrubbing of first the adjacent skin and then the wound itself with a solution of mild soap and water. This removes the dirt and with it most of the bacteria. During this gentle scrubbing, thorough irrigation of the wound with a soapy solution is carried out. After that is done, a sterile dressing is applied and over this dressing some fluffed gauze so that firm pressure is applied over the wound.

Wounds so treated will almost invariably heal without signs of inflammation. Wounds that are bruised or gouged-out, such as are caused by grinding wheels, have the dirt ground in the tissues so deeply that simple scrubbing

will not cleanse the wound sufficiently. These roughened areas should be excised with a sharp pair of scissors or knife, the entire area of the wound being so treated, thus converting the wound into an incised wound of the type that will heal readily. If extensive, of course, these wounds should be sent to the physician as local anesthesia facilitates the trimming or debridement of these wounds. If the wound is seen early and carefully cleansed, it should be closed by the insertion of small skin clips which are so easily applied that they lend themselves nicely to use by a nurse. Flamed adhesive strips are also helpful in keeping the wound closed. Obviously, wounds requiring sutures other than a clip or two should be seen by the physician.

Primary closure of wounds is the ideal method and results in far more rapid healing, assuming the above procedure has been carried out. If, however, the wound is over six hours old or of a nature which cannot be well cleansed, it should be left open and a moist dressing applied. Incidentally, the use of nonabsorbable suture material such as cotton and of stainless steel wire has been found to be much more useful than catgut whether buried in the tissues or used in the skin.

ANTISEPTICS

It is quite well recognized that an antiseptic which will kill most bacteria will also harm the tissues. Therefore, if

HAND AND FOOT INJURIES

wounds are thoroughly cleansed with soap and water an antiseptic is not necessary. However, we have the psychology of the patient to consider and most patients, perhaps, feel more satisfied if some antiseptic is used. There is very little, if any, harm in applying a few drops of a mild antiseptic by means of a medicine dropper if you wish. However, this antiseptic must be very mild and of an aqueous type. Because of the impracticability of having large quantities of sterile saline or sterile water in the plant dispensary, we like to irrigate these wounds after the soap and water cleansing with a solution of azochloramid. In this way voluminous irrigations can be carried out as the solution is easily prepared and is very mild.

The sulfonamide drugs have been shown to be very valuable in the prevention of wound infection. An atomizer containing sulfanilamide powder is a very useful way of spraying wounds before closing them and a very valuable way to prevent infection. Sulfathiazole is also valuable but it tends to cake and is harder to use through an atomizer.

If a wound is of such severity that it is to be sent to the physician or hospital, it is best to do nothing more than apply a sterile dressing or bandage in order to avoid additional contamination of the wound. It is best to have all the cleansing done at one sitting in the hospital as it all has to be done over again by the doctor, anyway. However, spraying these wounds with sulfanilamide powder is a good thing as it will aid in keeping the bacteria inactive until the wound is surgically handled in the hospital. This is especially true when there may be some delay before the physician can take care of the patient.

Droplets from the nose and throat are among the most potent sources of wound infection. No nurse who has a sore throat or cold should handle wounds.

If all the nurses wore operating-room masks it would doubtless cut down the occurrence of infections.

The control of bleeding such as is seen on the hands and feet is usually readily achieved by the use of direct pressure over the wound. On the fingers it is a simple matter to apply a temporary tourniquet by means of a rubber band at the base of the finger. When bleeding from the hand is so severe that it cannot be stopped, an elastic rubber-tubing tourniquet should be applied halfway between the elbow and shoulder with towelling or gauze under it to avoid undue pressure on the nerves. This tourniquet should never be left on for more than 15 minutes, after which it may be loosened and then reapplied.

In the aftercare of wounds, it is best to use simple measures and not overtreat them. If a wound is closed and clean, a dry, sterile dressing is sufficient. For wounds which are open and granulating, a nonadherent vaseline gauze dressing is very effective. In this vaseline there may be incorporated some mild agent such as cod liver oil, xeroform, or one of the sulfonamides.

One of the most important factors in the care of wounds of the hands is the diagnosis of severed tendons. A small incised wound caused by a small sharp object is dangerous. On the dorsal surface the tendon is close to the surface and on the palmar surface, especially in the flexion creases, one must always be suspicious of a severed flexor tendon. A helpful procedure in ascertaining the depth of a wound is by inserting a sterile hemostat and spreading the tissues apart; thus a partially severed tendon previously obscured may come into view when the patient is told to bend the finger joints up and down. To test for finger tendon function, hold the patient's finger firmly fixing all the joints except the end and then have the patient try to

forcibly bend the end of the finger downward and upward. Failure to do this indicates a severed flexor or extensor tendon, respectively.

Unfortunately, this test is not entirely reliable as regards the extensor tendons because they have such wide extensions over the back of the fingers that enough continuity remains to allow fairly good function even though much of the tendon is severed. A partially severed flexor tendon will allow good initial function also. If left alone the unsevered portion of the tendon will soften in a few days and may give way if the patient attempts to use the finger forcibly. Excess scar will form and this will interfere with function. Therefore the physician should explore all such wounds to make sure the tendon is not injured sufficiently to cause subsequent trouble. This is particularly true of the flexor tendons. If the extensor tendon is only partially severed it will heal nicely if the finger and wrist are kept in a hyperextension splint for from three to six weeks. So do not take chances with wounds that lie over the tendons but refer them to the physician.

INFECTIONS

Infections of the hands are very important as they are a source of much functional disability. Most hand infections occur from minor untreated wounds such as punctured wounds or minor abrasions proving the importance of treating wounds immediately as I stated previously. The common paronychia is readily recognized by the angry appearance of the flesh just lateral to the base of the nail. If this does not subside with moist dressings and hot soaks, it will have to be lanced by the physician.

Infections in the pulp are common and potentially serious. They are manifested by a tenseness of the tip of the finger, tenderness on pressure, and a painful throbbing such that the patient cannot

sleep. When these findings are present it means that immediate surgical incision is necessary and there should be no delay as it may cause an osteomyelitis of the finger tip which may be months in healing. This type of infection is so deep in the pulp that one does not get the usual signs of redness and fluctuation. Hence, waiting for these signs to develop means the diagnosis will be made too late.

Infections of the tendon sheaths on the flexor aspect of the hand are manifested by redness and tenderness with excruciating pain when the finger is hyperextended. These require hospitalization and should be sent to the physician at once. Where red streaks are seen running up the hand and forearm it means lymphangitis. This requires hot packs with elevation of the part and bed rest. The use of sulfonamides is very helpful here. Surgery is contra-indicated in lymphangitis, only being done when a localized abscess appears.

Small steel particles, if deep and causing no trouble, are best left alone. Copper particles usually cause irritation and should be removed, although if very small and superficial, this can often best be done later after a tiny zone of irritation appears. Sometimes the patient is greatly concerned about a foreign body; when this occurs it is often best to remove it. Ordinary graphite lead pencil fragments are relatively innocuous but fragments of indelible lead are very important in that they cause a chemical necrosis of the adjacent tissues and, therefore, should be sent to the physician as he will wish to excise all the stained adjacent tissue.

The same applies to splinters of magnesium metal. Little gas tumors form around the magnesium splinters and cause necrosis of the adjacent tissues. Hence the fragment should be removed immediately. This applies to pure magnesium; alloys of magnesium may not

cause trouble if the magnesium content is low. Wood splinters, of course, should be removed routinely as they cause irritation and infection. If they are of any length one can usually determine their presence by taking both index fingers and pressing them opposite one another, placing one of the finger tips over each end of the suspected sliver.

PUNCTURES AND FRACTURES

Punctured wounds of the feet are quite common and in almost every instance they cause a flaplike valve which closes over the punctured tract. This flap should be excised as well as the calloused skin at the site of entrance, transforming the tract into a funnel. The surrounding skin and wound should be thoroughly cleansed with soap and water. Foreign material is invariably found beneath the flap and ordinarily most of this can be removed with a fine forceps or by irrigating the tract by means of a bulb syringe and cannula tipped needle. A moist dressing should be applied and hot soaks at home are always most helpful.

The question of the use of tetanus antitoxin is one which your plant physician should decide. Tetanus very rarely develops from machine-shop injuries. In general, the deeper punctured wounds, any grossly contaminated wounds, and particularly those seen late or exhibiting evidence of inflammatory reaction should have antitoxin. One should always inquire as to a history of allergy before giving tetanus antitoxin because annoying and even serious reactions may occur. Wounds contaminated by street-dust are particularly suspicious. Tetanus may develop following a slight abrasion and occasionally crops up where least expected. Because of possible reactions or subsequent sequelae, antitoxin should be administered under a physician's supervision and at his direction.

A common finger injury is an involve-

ment of the fibrocartilage of the middle joint, manifested by a firm swelling, pain, and impaired function. These last a long time and not infrequently cause permanent thickening and disability. Physical therapy and massage are the best treatment and, except during the acute stage, the patient should be encouraged to indulge moderately in the use of the joint.

The only way to rule out the presence of fracture is by X-ray. Most fractures involve the shafts of the phalanges and are best treated in flexion. Early motion is desirable as fingers stiffen up quite rapidly when not used. Massage and physical therapy are very valuable here. It is always important to see that the patient is taught to keep the uninjured fingers in motion as patients have the bad habit of keeping the entire hand at rest when one finger is injured, frequently causing disability of the whole hand. The hand, whenever possible, should be maintained in the "position of function" which is approximately the position of the hand in grasping a water tumbler.

The so-called "baseball" finger with a drooping of the distal phalanx results from a tearing loose of the extensor tendon with or without an avulsion of a bit of bone. This is best treated by using the Lewin splint which keeps the finger tip hyperextended. This splint should be kept on at least six weeks and should never be removed during that interval. It requires no bandage and the patient may wash and dry the finger with little inconvenience.

BURNS

Burns are treated according to the same principles that we have emphasized in the care of wounds as burns are simply wounds caused by a thermal or chemical agent. It is very difficult to gauge the depth of a burn when it is first seen. The history is helpful in determining the

PUBLIC HEALTH NURSING

depth of the burn as all burns caused by burning clothes or molten metal are always very deep whereas the scalds are usually more superficial. A whitish-gray dull appearance usually indicates a deep burn.

Burns should be thoroughly cleansed with soap and water and the loose skin blebs removed. Following this some sulfanilamide powder may be sprayed on the area, then a mild nonadherent dressing of plain or medicated vaseline gauze used, over which ample gauze fluffs are placed so that the bandage produces a firm but comfortable pressure. There is no magic burn salve. The simple methods are the best. Tannic acid preparations are not well adapted to office or dispensary use. All extensive burns should be sent to the hospital. Burns of the hands heal rapidly whereas burns of the feet and legs heal very much more slowly.

Fractured toes cause very little trouble and a fancy reduction is not needed. Using the adjacent toe as a splint by means of adhesive tape, strapping the two toes together, works quite well. Extensive fractures of the great toe are more painful and may require a light cast or some type of splint, with freedom from weight-bearing for a moderate period. Many cases of fractured metatarsals can be made ambulatory in ten days after the swelling has subsided by means of wearing a regular shoe with a Gebhard foot-piece applied—simply a

bar of wood screwed across the shoe about 1½ inches in front of the heel. This takes the weight off the painful area and these patients become ambulatory very much earlier.

Sprains of the fingers, wrist, foot and ankle joints are common. The tenderness in a sprain is directly over a joint whereas in a fracture the tenderness is most marked directly over the bone. This sign fails, of course, in joint fractures. Therefore, the only way to be sure is by X-rays and we believe in very free use of X-rays. Simple support by bandaging or adhesive strapping is effective. Early use in mild sprains is effective but in the more severe sprains complete rest for varying periods is needed. Hot soaks, therapeutic heat treatments, and massage are helpful.

The industrial nurse should follow correct, fundamental principles in handling injuries and should avoid becoming addicted to or developing unmerited confidence in certain pet medicaments. Too many are prone to forget that it is the body itself that supplies the healing power. If we keep clean, use clean materials, and carefully cleanse all injured areas promptly, our body tissues will do the rest. The wise nurse will take no chances; part of her responsibility consists in having the physician see every injury about which she is in doubt.

From a talk delivered before the National Safety Council's 31st Annual Safety Congress, October 28, 1942, Chicago, Illinois.

Nursing Education at Chicago

(Continued from page 344)

the remarkable job directors of schools of nursing are doing for our profession under great handicaps. Even though it may be impossible for public health nursing agencies to give field experience to student nurses, some help can always be

given to the faculty of the school of nursing in preparing nurses for community service.

Let our first step in cooperation be membership in the League, and the second be participation in its activities. That will make public health nurses increasingly helpful to the schools of nursing in their communities.

Reviews and Book Notes

HEALTHY BABIES ARE HAPPY BABIES

By Josephine Hemenway Kenyon, M.D. 343 pp. Little, Brown and Company, Boston, 3rd edition revised, 1943. \$1.50.

Here is a reliable handbook for the mother who is expecting a baby. It will continue to give her guidance in the care of herself and her baby until the child is three years old. The style is delightful and the content well organized. The writer anticipates many of the physical and mental health problems of babies and parents and suggests ways of meeting and of avoiding them. This book contains some real help in handling emergencies. The instructions are clear and easy to follow. New material has been added to bring the scientific facts in this revision up to date.

HATTIE HEMSCHEMEYER, R.N.
New York, N. Y.

DISORGANIZATION—PERSONAL AND SOCIAL

By Ernest R. Mowrer, Ph.D. 682 pp. J. B. Lippincott Company, Philadelphia, 1942. \$3.75.

Dr. Mowrer's book presents a systematic analysis of some of the major problems of personal and social disorganization. His frame of reference is social psychology. Social change, social disorganization and personal disorganization all have their genesis in the variant behavior of individuals. All social change involves some social disorganization and all personal disorganization represents behavior upon the part of the individual which deviates from the culturally approved norm to such an extent as to arouse social disapproval. The attitude of society toward variant behavior and the response of the individual to social disapproval lays the groundwork for the basic types of personal disorganization which are: (1) active rebellion against the social order,

the goal of which is defined in terms of social welfare (2) active rebellion directed toward hedonistically defined goals and (3) the subjective withdrawal from participation in the social order. Having laid down his theoretical structure the author proceeds to analyze typical lines of personal development as they eventuate in the several types of disorganized personalities such as: the inventor and innovator, the nonconformist and rebel, the reformer and revolutionist, the juvenile and adult delinquent, the unadjusted personality including the neurotic and psychotic, the alcoholic, the sexual variant, the suicide.

In his analysis of these various manifestations of personal disorganization, Professor Mowrer gives great amounts of statistical data and condenses information from many authors. The book which is dull and difficult reading has little value for nurses and social workers except as a reference.

HELEN I. CLARKE
Madison, Wisconsin

THIS IS MY LIFE

By Agnes Hunt. 237 pp. G. P. Putnam's Sons, New York, 1942. \$2.50.

It is with a feeling of gratitude to Sir Robert Jones and his son that a reader closes the covers of Dame Agnes Hunt's autobiography for, "they," she says, "are to blame for it."

Miss Hunt tells of her mother's "indomitable pluck." Certainly she inherited it and possesses as well, all the qualities she names as requirements for a good nurse.

Surely she who "felt the call to help my fellow cripples, until it became a positive obsession," has been an inspiration to the two institutions which bear her name.

PUBLIC HEALTH NURSING

Seventy-six years of remarkable achievement have only been possible by the family philosophy of sink or swim and it is certain that Dame Hunt's sense of humor kept her from sinking!

To those who have met her, the book brings to mind a vivid picture of this cheerful and courageous pioneer in orthopedic nursing. To all others it is a stimulating introduction.

The apt illustrations add greatly to the book.

JESSIE COWEN SOWDEN, R.N.
Anaheim, California

LEARNING AND TEACHING IN THE PRACTICE OF SOCIAL WORK

By Bertha Capen Reynolds. 390 pp. Farrar and Rinehart, Inc. New York, 1942. \$2.50.

This is a book which teachers and supervisors of public health nurses cannot afford to miss. To be sure, it is directed toward the learning and teaching of social work; but because social work and public health nursing have so much in common and because the author has been rather general in her presentation of material, it should be of much value to those concerned with the learning and teaching of public health nursing.

A concept of what the learning of an art involves is set forth with an analysis of the use of conscious intelligence in that process. Group discussion, as a method of learning and teaching, is taken up in considerable detail. Nearly a third of the book is devoted to the supervision of field practice with emphasis on the relationship of the learner and the supervisor during this learning period. It seems that this might be particularly valuable to supervisors of public health nurses.

The author has made use of footnotes to refer the reader to related sections of the book as she developed her subject. The book includes a very complete index and a lengthy bibliography to which frequent reference is made.

This reviewer would like to stress that her purpose has been to evaluate this book for its possible contribution to the learning and teaching of public health nurses. It would seem that those concerned with the preparation of the public health nurse would find it, although directed toward another profession, a valuable contribution to our own.

LUCIA M. SWEETON, R.N.
Washington, D. C.

RECENT PUBLICATIONS AND CURRENT PERIODICALS

GENERAL

THE 1942 YEARBOOK OF PHYSICAL THERAPY. Edited by Richard Kovacs, M.D. The Year Book Publishers, Inc., Chicago, 1942. 416 pp. \$3.

PROCEEDINGS OF THE EIGHTH SCIENTIFIC CONGRESS May 10-18, 1940, under the auspices of the Government of the United States of America. Vol. VI Public Health and Medicine. Edited by Secretariat of the 8th American Congress in collaboration with the Division of International Conferences of the Department of State, Washington, D. C. 1942. 496 pp.

HEALTH PROBLEMS IN NEGRO COLLEGES: Proceedings of 1st and 2nd Annual Meetings of

the National Student Health Association. National Tuberculosis Association, 1790 Broadway, New York City. January 1943. 92 pp.

WHERE CAN WE GET WAR WORKERS? Sanford Griffith. Public Affairs Pamphlet No. 75. Public Affairs Committee, 30 Rockefeller Plaza, New York City. 1942. 32 pp. 10c.

ADMINISTRATION

"A SELF-HELP SOLUTION OF STATE PERSONNEL PROBLEMS." Joseph W. Mountin, M.D. *Public Health Reports*, U. S. Public Health Service, Superintendent of Documents, Washington, D. C. February 19, 1943. p. 297. Single copy 5c.

BOOK NOTES

A STUDY IN PUBLIC RELATIONS. Harold P. Levy. Russell Sage Foundation, New York City, 1943. 165 pp. \$1.

BOARD COMMITTEE AND VOLUNTEER

VOLUNTEERS IN THE SCHOOLS. O.C.D. Publication 3619. United States Office of Civilian Defense, Washington, D. C. Available from state and local defense councils. Free.

CHILD HEALTH

STANDARDS OF CHILD HEALTH, EDUCATION AND SOCIAL WELFARE: Based on Recommendations of the White House Conference on Children in a Democracy and Conclusions of Discussion Groups. U. S. Children's Bureau Publication No. 287. Superintendent of Documents, Washington, D. C. 1942. 21 pp. 10c.

WHITE HOUSE CONFERENCE ON CHILDREN IN A DEMOCRACY: Final Report. U. S. Children's Bureau, Publication No. 272. Superintendent of Documents, Washington, D. C. 1942. 393 pp. 65c.

COMMUNICABLE DISEASE

VENEREAL DISEASE CLINICS: 1943 Directory. U. S. Public Health Service, Superintendent of Documents, Washington, D. C., 1943. 124 pp. 25c.

INDUSTRIAL

INDUSTRIAL HEALTH PRACTICES. A report of a survey of 2,064 industrial establishments under the direction of Dr. Victor G. Heiser. National Association of Manufacturers, 14 West 49 Street, New York City. October 1941. 76 pp. Free.

TWO PAMPHLETS available from Industrial Welfare Department, Zurich Insurance Company, 135 La Salle Street, Chicago, Illinois.

Industrial Fatigue. Meyer Brown, M.D. 18 pp. Free.

Problems of Labor Supply for War Production. John S. Nagel, M.D. and Meyer Brown, M.D. 35 pp. 1942. Free.

"A PSYCHIATRIST LOOKS AT INDUSTRIAL TRUANCY." Lowell S. Selling, M.D. *Industrial Medicine*, Industrial Medicine Publishing Company, 605 No. Michigan Avenue, Chicago. April 1943. p. 189. 50c.

EYE HEALTH

SOME DON'T'S TO DO: A GUIDE FOR THE SIGHTED. J. Robert Atkinson. *Light*. Braille

Institute of America, Inc., 714 N. Vermont Avenue, Los Angeles. October 1942.

DIRECTORY OF EYE SERVICES IN NEW YORK CITY—1942. Prepared by Committee on Eye Services, Section on Medical Social Service, Welfare Council of New York City, 44 East 23 Street. 1942. 32 pp. 10c.

NURSING

LIPPINCOTT'S QUICK REFERENCE BOOK FOR NURSES. Compiled and arranged by Helen Young, R.N., with the assistance of Georgia A. Morrison, R.N. and Margaret Eliot, R.N. J. B. Lippincott Company, Philadelphia, 1943. 5th Edition, completely revised. \$2.

The new edition has been brought up-to-date by the addition of material on the sulfa drugs, poison gases, shock and immunization. As the publishers say, "... this handy reference book has literally 'gone to war'!"

PUBLICATIONS, RECORDS, PHOTOGRAPHS, SLIDES. National League of Nursing Education, 1790 Broadway, New York City. March 1943. 13 pp. Free.

A list of materials available from the League for purchase or rental.

A FAMILY OF THIRTY MILLION. Louis I. Dublin, Ph.D. Metropolitan Life Insurance Company, 1 Madison Avenue, New York City. 1943. 496 pp.

Chapter XX, "A Program of Welfare" is of special interest to our readers. This is an interesting account of the beginning of the M.L.I. Nursing Service but it is disappointing in not giving much detailed information about the service in recent years.

RED CROSS

TWO PAMPHLETS available through local Red Cross chapters to any nurse teaching home nursing classes. The American National Red Cross, Washington, D. C.

Handbook of Information on Red Cross Home Nursing, ARC 759. 42 pp.

A Teaching Guide for Instructors of Red Cross Home Nursing, ARC 714. 81 pp.

NUTRITION

"DIETARY CONDITIONS IN INDUSTRY." Robert Goodhart, M.D. *The Journal of the American Medical Association*, 535 North Dearborn Street, Chicago, January 9, 1943. p. 93. 25c.

NUTRITION NOTES. The Nutrition Bureau, Community Service Society, 105 East 22

PUBLIC HEALTH NURSING

Street, New York City. Monthly, September through June. 4 pp. 5c a copy or 50c a year.

PROVIDING LEADERSHIP IN NUTRITION EDUCATION THROUGH REFRESHER COURSES. Issued jointly by Home Economics Service of U. S. Office of Education and Nutrition Division of the Office of Defense Health and Welfare Services. Available from Nutrition Division of the Office of Defense Health and Welfare Services. 1943. 34 pp. (Mimeographed).

FOOD IN THE LIVES OF OUR NEIGHBORS: A Study of Community Service in Nutrition Education. Earl Lowon Koos. The District Health Committee, Kip's Bay-Yorkville Health District, 411 East 69 Street, New York City. 1942. 47 pp. \$1.

ITALIAN FOOD PATTERNS AND THEIR RELATIONSHIP TO PROBLEMS OF FOOD AND NUTRITION. Genoeffa Nizzardini and Natalie F. Joffe. Available from Committee on Food Habits, National Research Council, 2101 Constitution Avenue, Washington, D. C. 1942. 23 pp. Free. (Mimeographed).

MENTAL HYGIENE

"MENTAL HYGIENE PROBLEMS OF STUDENT NURSES." David A. Boyd, Jr., M.D. *Mental Hygiene*, National Committee for Mental Hygiene, 1790 Broadway, New York City. April 1943. p. 198. 15c.

EMOTIONAL HYGIENE. Camilla M. Anderson,

M.D. J. B. Lippincott, Philadelphia. 3rd Edition, 1943. 253 pp. \$2.

This very useful book for public health nurses has been made more practical to meet changing world conditions, and much new and cogent illustrative material added.

HEALTH EDUCATION

"THE TREATMENT OF UNCOMPLICATED DUODENAL ULCER." Lucian A. Smith, M.D. and Andrew B. Rivers, M.D. *The Journal of the American Medical Association*, 535 N. Dearborn Street, Chicago, May 22, 1943. p. 209. 25c.

TWO REPRINTS from *Hygeia*. American Medical Association, Chicago, Illinois.

Psoriasis. Maurice J. Costello, December 1942. 4 pp. 10c.

Syphilis—The Great Tragedian. Greer Williams. March 1943. 8 pp. 10c.

"PARENTAL AND FAMILIAL FACTORS IN THE ACCEPTANCE OF DIPHTHERIA AND SMALLPOX IMMUNIZATION." Lester Breslow, Pearl Shalit and Gaylord Anderson. *Public Health Reports*, Superintendent of Documents, Washington, D. C. March 5, 1943. p. 384. 5c.

MATERNITY

THE CASE WORKER AND FAMILY PLANNING. The Planned Parenthood Federation of America, 501 Madison Avenue, New York, 1943. 43 pp. 10c.

NURSE PLACEMENT SERVICE

N. P. S. announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom consent to publish these has been secured in each case from both nurse and employer.

PLACEMENTS

*Susan M. Purtell, director of public health nursing, Marquette University, Milwaukee, Wis.

*Mabel L. Nodwell, nursing consultant, American Red Cross, Pacific Area, San Francisco, Calif.

*Hilda May George, public health nursing instructor, Keuka College, Keuka Park, N. Y.

*Janis M. Gerking, orthopedic nurse, Division of Services for Crippled Children, Springfield, Ill.

Olga Ruth Stenbro, industrial nurse, J. J. Tourek Company, Chicago, Ill.

Mrs. Adele D. Zaph, industrial nurse, Canedy-Otto Company, Chicago Heights, Ill.

*Mrs. Dorothy J. Baumann, staff nurse, Visiting Nurse Association, Inc., Los Angeles, Calif.

ASSISTED PLACEMENTS

*Antoinette B. Wajdyk, director, Visiting Nurse Association, Sioux City, Iowa

*Marion A. Curtis, staff nurse, Territorial Department of Health, Juneau, Alaska.

*The N.O.P.H.N. files show that this nurse is a 1943 member.

NOTES FROM THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

IN THE FIELD

MINNESOTA HOSPITAL ASSOCIATION, Minneapolis, May 24—Jessie L. Stevenson spoke briefly on services to schools of nursing available from JONAS, and showed our set of 60 Kodachrome slides depicting correct and incorrect posture in rest and activity. . . . COMMUNITY HEALTH SERVICE OF MINNEAPOLIS—Miss Stevenson gave an illustrated talk to the staff on Orthopedic Implications in Nursing Care. . . . MINNESOTA CHAPTER OF THE AMERICAN PHYSIOTHERAPY ASSOCIATION, May 25—Miss Stevenson spoke on Ways in Which Physiotherapists Can Contribute in Teaching the Student Nurse. . . . UNIVERSITY OF MINNESOTA, SCHOOL OF NURSING, May 27—Miss Stevenson spoke to students in five-year program and discussed opportunities in the field of orthopedic nursing and orthopedic implications in nursing services. . . . THIRD DISTRICT OF THE MINNESOTA STATE LEAGUE OF NURSING EDUCATION, June 2—Miss Stevenson spoke on Integration of Orthopedics in Teaching Programs for Nurses. . . . SETON HALL COLLEGE, Newark, N. J., June 2—Mrs. Bethel McGrath lectured on industrial nursing to a class of students in the summer course on Industrial Hygiene for Nurses. . . . ST. PAUL FAMILY NURSING SERVICE, June 9—Miss Stevenson spoke on Posture in Nursing Activities, illustrated by Kodachrome slides. . . . Chicago, Illinois, June 13-19—Mary C. Connor and Leah M. Blaisdell, chairman of the Education Committee, attended meetings of the National League of Nursing Education and the Association of Collegiate Schools of Nursing. . . . Chicago, Illinois, June 17-

19—Ruth Houlton attended the meeting of the National Nursing Council for War Services for State Nursing Council Executive Secretaries and Staffs of Government Agencies; the meeting of the Joint Committee of the A.N.A. and N.O.P.H.N. to Coordinate the Work of These Two Organizations with Regard to Industrial Nursing; and an Institute for Executive and Elected Secretaries of State Nursing Associations. At the latter meeting, Miss Houlton gave a brief resumé of activities of SOPHN's and their implications for SNA's.

ADJUSTING THE WORK WEEK

This letter from the executive director of the Visiting Nurse Association of Springfield, Massachusetts, will interest agencies with 48-hour week problems:

In reply to your letter of April 23 requesting information on our application of the President's Order No. 9301 [48-hour week], our lawyer has had the question under advisement for some time and until quite recently felt the wording of the law was not sufficiently clear for him to interpret it as it affected our agency.

We in the agency have been doing quite a bit of thinking on it and have now come to the conclusion that already the number of hours to comply with the directive are being utilized in travel time for servicing and garaging cars, irregular lunch hours due to overtime work, advanced office hours and evening volunteer work.

Furthermore, applying the 48-hour week to the agency would not reduce the personnel as we are already short-staffed to meet the present "priorities" requirements. Neither would "public relations" be affected materially by such action because most communities feel that nurses work long and hard for everything they get. Our Board was unanimously opposed to regimenting the work week any more than we have done for fear that it might seriously affect the health of our already depleted staff. On this

PUBLIC HEALTH NURSING

thinking the agency requested clearance from the order and it was granted on May 5th.

The family welfare agency has also recently received clearance. You may be interested to know that they set their working day as 9 to 5 with no scheduled lunch hour, which allowed them to list their working day as of 8 hours. The fact that they may have luncheon meetings or scheduled appointments with workers to discuss cases over lunch, as well as visits on Saturday afternoons and Sundays was pointed out. Time was even included for necessary reading and studying, something I think most nursing agencies feel should be done on nurses' own time.

TWO NEW N.O.P.H.N. GUIDES

N.O.P.H.N.'s new publication, "Volunteers and Auxiliary Workers in Public Health Nursing: A Guide to Their Selection, Training and Use," has been purchased by the OCD for distribution to state and local defense councils. Of the pamphlet Reginald C. Foster, assistant director in charge of OCD Civilian War Services said, "Two kinds of training are outlined: that suitable for volunteers who have completed nurse's aide training and that suitable for volunteers with no previous experience in the nursery field. The section on training is full and contains considerable valuable information."

A general discussion of the need to promote pay service at this time and concrete suggestions about ways and means of doing so through an intensive year-round publicity program are included in the guide "Promotion of Pay Service" prepared by the Board and Committee Members Section.

Both publications are now available from the N.O.P.H.N. at a cost of 25 cents each.

HONOR TO GRACE ROSS

Grace Ross, director of public health nursing of the Detroit Department of Public Health and president of the N.O.P.H.N. 1938-1942, was awarded the degree of Doctor of Science in Nursing at

the annual commencement exercises of Wayne University, Detroit, on June 17.

Dr. Warren E. Bow, president of the University, in conferring the degree said: "Interested in problems of nursing education, she has helped to raise the level of training and licensure. A professional woman who is a nationally recognized leader in her field, she has implemented vigorously her rapidly developing vision. The health of our community is better and life is safer for her presence and work among us."

HONOR ROLL

Are you the one nurse who is keeping your agency off the Honor Roll? If you're holding up the 100 percent enrollment of your staff, won't you send your membership dues today and see to it that your agency is listed on the Roll of Honor?

Don't forget that any nursing staff whether of school, industry, health department, visiting nurse association, or any other organization is eligible. And one-nurse services too! Be sure to notify us as soon as your staff is 100 percent enrolled. That is the only way we have of knowing when to send your Honor Roll Certificate and to add the name of your agency to the growing list of Honor Roll Agencies.

ALABAMA

*Guntersville—Marshall County Health Department

Vernon—Lamar County Health Department

ARKANSAS

*Paragould—Greene County Health Department

COLORADO

*Boulder—City Health Department

CONNECTICUT

*Bridgeport—Public Health Nursing Association of Easton

*Agencies which have been on the Honor Roll for five years or more.

N.O.P.H.N. NOTES

- *Canaan—North Canaan Visiting Nurse Association
- *Cheshire—Public Health Nursing Association
- Clinton—Public Health Nursing Association
- Collinsville—Canton Public Health Nursing Association, Inc.
- East Hartford—Public Health Nursing Association
- *Lakeville—Salisbury Public Health Nursing Association
- *Manchester—Public Health Nursing Association
- *Naugatuck—American Red Cross
- *New Canaan—Visiting Nurse Association
- New Preston—Visiting Nurse Association
- *Newtown—Visiting Nurse Association
- Norwalk—Metropolitan Life Insurance Nursing Service
- *Plainfield—Metropolitan Life Insurance Nursing Service
- *Putnam—Red Cross Public Health Nursing Service
- *Stafford Springs—American Red Cross Public Health Nursing Service
- Warehouse Point—East Windsor Public Health Nursing Association
- West Cornwall—Cornwall District Nurse Association
- Woodbury—Red Cross Community Nurse Association, Inc.

FLORIDA

- *Jacksonville—Metropolitan Life Insurance Nursing Service
- *Orlando—Metropolitan Life Insurance Nursing Service

ILLINOIS

- *Belleville—Public Schools
- *Belleville—Metropolitan Life Insurance Nursing Service
- Carlinville—Macoupin County Tuberculosis & Sanatorium Board
- Decatur—Department of Public Health and Safety
- *Freeport—Stephenson County Tuberculosis Board
- Granite City—John Hancock Mutual Life Insurance Company
- *Hinsdale—Board of Education
- Kankakee—County Tuberculosis Sanatorium Committee
- Melrose Park—Salar-Sturges Manufacturing Company
- Oak Park—Department of Health
- *Oregon—Ogle County Tuberculosis Sanatorium Board
- Ottawa—Township High School

- *Pekin—Community High School
- *Peoria—Visiting Nurse Association
- *Sycamore—DeKalb County Nursing Service
- *Winnetka—Family Welfare Society

INDIANA

- *Angola—City Schools
- English—Crawford County Nursing Service
- *Evansville—Public Schools
- *Fort Wayne—Red Cross Public Health Nursing Service of Allen County
- *Fort Wayne—Tuberculosis Association of Allen County
- *Goshen—Elkhart County Tuberculosis Association
- *LaPorte—County Public Health Nursing Service
- Marion—Metropolitan Life Insurance Nursing Service
- New Albany—District Health Department No. 3
- *New Albany—Floyd County Tuberculosis Association
- *New Castle—Public Health Nursing Association
- Rensselaer—Jasper County Public Health Nursing Service
- Shelbyville—County Public Health Nursing Service
- *Terre Haute—City Schools Hygiene Department
- Tipton—County Public Health Nursing Service
- Whiting—Red Cross Nursing Service

IOWA

- *Charles City—Board of Education
- Decorah—Public School
- Des Moines—Polk County Tuberculosis Association
- Iowa City—Bureau of Dental Hygiene
- Jefferson—Green County Nursing Service
- Leon—Decatur County Nursing Service
- *Maquoketa—Jackson County Public Health Nursing Service
- *Marshalltown—Community Nursing Service
- *Marshalltown—Independent School District
- *Muscatine—Public Health Nursing Association
- *Ottumwa—Metropolitan Life Insurance Nursing Service
- *Sac City—Public Health Nursing Service

KENTUCKY

- Columbia—Adair County Health Department
- Covington—John Hancock Life Insurance Company Nursing Service
- Liberty—Casey County Health Department

PUBLIC HEALTH NURSING

LOUISIANA

St. Martinsville—St. Martin Parish Health Unit

MAINE

Bangor—Department of Education

*Belfast—Waldo County Chapter American Red Cross

Dexter—Public Health Association

*Lewiston—Lewiston-Auburn Chapter American Red Cross

Portland—Cumberland County Public Health Association

*Saco—York County Chapter American Red Cross

Southwest Harbor—Maine Public Health Association

Waterville—Metropolitan Life Insurance Nursing Service

MARYLAND

Cambridge—Dorchester County Tuberculosis Association

Cumberland—Metropolitan Life Insurance Nursing Service

Easton—Talbot County Health Department

Hyattsville—Metropolitan Life Insurance Nursing Service

MASSACHUSETTS

*Arlington—Board of Health

*Arlington—Visiting Nursing Association

*Cambridge—Visiting Nursing Association

Duxbury—Nurse Association

Millbury—Society for District Nursing

*Northampton—Visiting Nurse Association, Inc.

*West Springfield—Neighborhood House Association

MICHIGAN

Benton Harbor—Health Service—Board of Education

*Detroit—North End Clinic

*Detroit—Out Patient Nursing Service

*Flint—Genesee County Health Department

Iron Mountain—Dickinson County Health Department

*Mason—Ingham County Health Department

MINNESOTA

*Duluth—State Teachers College Nursing Service

Minneapolis—Industrial Nurse Service—General Mills

*Minneapolis—State Department of Health, Division of Public Health Nursing

MISSOURI

Bolivar—Polk County Public Health Nursing Service

Hillsboro—Jefferson County Public Health Nursing Service

*Jefferson City—Board of Education

*Kansas City—Visiting Nurse Association

Platte City—County Health Unit

Sedalia—Pettis County Public Health Nursing Service

Webb City—Jaspar County Health Department

NEBRASKA

Lincoln—Lincoln and Lancaster County Tuberculosis Association

NEW HAMPSHIRE

*Center Ossipee—Ossipee Chapter American Red Cross

*Concord—State Board of Education

*Keene—Union School District

*Pittsfield—District Nursing Association

NEW JERSEY

*Camden—County Tuberculosis Association

Dunellen—Board of Education

*Elizabeth—Visiting Nurse Association

Haddonfield—Public Schools

Maywood—Public School

*Newark—New Jersey State Teachers College

*Ridgefield—Lowe Paper Company

*Salem—Child Welfare and Visiting Nurse Association

*Salem—City Board of Education

*Toms River—Ocean County Tuberculosis and Health Association

NEW YORK

*East Aurora—American Red Cross

*Fulton—Metropolitan Life Insurance Nursing Service

*Mechanicville—Metropolitan Life Insurance Nursing Service

*Millbrook—Visiting Nurse Committee

Mineola—Nassau and Suffolk Counties Committee on Mothers' Health Centers

*New York, N. Y.—Judson Health Center

*Ogdensburg—Metropolitan Life Insurance Nursing Service

*Patchogue—Metropolitan Life Insurance Nursing Service

Peekskill—Metropolitan Life Insurance Nursing Service

*Peekskill—Public Health Association of Putnam Valley and Kent District No. 1

Perry—Wyoming County Public Health Nursing Service

*Port Jervis—Metropolitan Life Insurance Nursing Service

*Port Washington—Village Welfare Society

*Poughkeepsie—Dutchess County Health Association

N.O.P.H.N. NOTES

- Purchase—Nursing Committee Health Center
- *Tuckahoe—Public Health Nursing Organization of Eastchester, Inc.
- Utica—New York State Department of Health

NORTH CAROLINA

- Currituck—Currituck-Dare District Health Department
- Raleigh—Metropolitan Life Insurance Nursing Service
- Wilkesboro—Wilkes County Health Department

OHIO

- *Akron—Metropolitan Life Insurance Nursing Service
- *Cleveland—University Public Health Nursing District
- Columbus—Columbus Cancer Clinic
- *Massillon—City Hospital Public Health Nursing Department
- Masury—General American Tank Car Corporation
- *Ravenna—Visiting Nurse Association of Ravenna

PENNSYLVANIA

- *Allentown—Metropolitan Life Insurance Nursing Service
- *Allentown—Visiting Nurse Service of Allentown
- *Altoona—Metropolitan Life Insurance Nursing Service
- Hamburg—Visiting Nurse Association
- *Latrobe—American Red Cross
- *Morrisville—Red Cross Community Nursing Service
- *Mount Pleasant—American Red Cross
- *Palmerton—School District
- Pottstown—Metropolitan Life Insurance Nursing Service
- *Pottstown—Public Schools
- Shamokin—Metropolitan Life Insurance Nursing Service
- Uniontown—Fayette County Tuberculosis Society
- Uniontown—Metropolitan Life Insurance Nursing Service
- West Hazleton—The Visiting Nurse Association of Hazleton and vicinity

RHODE ISLAND

- Apponaug—Warwick Health Department
- Apponaug—Warwick District Nursing Association
- *Bristol—District Nursing Association

- *Carolina—Richmond Visiting Nurse Association
- *Centerdale—North Providence District Nursing and Tuberculosis Association
- *Cranston—Universal Winding Company
- *East Greenwich—Visiting Nurse Association
- *Esmond—Smithfield Public Health League
- *Lincoln—School Nursing Service
- *North Providence—School Department
- *Pawtucket—Visiting Nurse Association of Pawtucket, Central Falls and vicinity
- *Portsmouth—Public Health Nursing Service
- Providence—Maternal and Child Health Division of State Health Department
- *Providence—Nicholson File Company
- Westerly—Visiting Nurse Association
- *Woonsocket—Public Health Nursing Association

SOUTH CAROLINA

- McCormick—County Health Department
- Newberry—County Health Department

VERMONT

- *Rutland—Metropolitan Life Insurance Nursing Service

VIRGINIA

- *Alexandria—Metropolitan Life Insurance Nursing Service
- Arlington—Bureau of Nursing Service
- *Danville—Metropolitan Life Insurance Nursing Service
- *Warrenton—Fauquier County American Red Cross

WEST VIRGINIA

- Bluefield—Metropolitan Life Insurance Nursing Service
- *Huntington—Tuberculosis Association
- Huntington—Metropolitan Life Insurance Nursing Service

WISCONSIN

- Juneau—Dodge County Health Department
- Kenosha—Metropolitan Life Insurance Nursing Service
- *Menasha—Board of Education
- Merrill—Lincoln County Health Department
- *Neenah—Health Department
- Neillsville—Clark County Public Health Nursing Service
- *Superior—Metropolitan Life Insurance Nursing Service
- Superior—State Venereal Disease Clinic
- Wausau—Metropolitan Life Insurance Nursing Service
- West Bend—Washington County Public Health Nursing

NEWS

Highlights on Wartime Nursing

STUDENT WAR NURSING RESERVE

On June 15 the Student War Nursing Reserve became a fact with President Roosevelt's signature on the Bolton-Bailey bill. Surgeon General Parran will administer the Reserve and has appointed Lucile Petry as director and Eugenia Spaulding as associate director. Miss Petry is on leave of absence as dean of the Cornell University School of Nursing. Students in the Reserve will receive a monthly stipend of \$15 for the first 9 months of study, \$20 for the following 15 to 21 months of combined study and practice. They must agree to serve either in the armed forces or in other federal or essential civilian services for the duration of the present war. The Advisory Committee representative of the various fields of nursing met June 25 to consider rules, regulations and standards for operation of the Reserve.

- Camp Community Visiting Nurses' Service, to supplement the program of official health agencies, has been set up by the American Red Cross in the vicinity of Army camps and defense plants, according to announcement made by Mary Beard, director of the Red Cross Nursing Service. Teaching of prenatal and postnatal care and maternity nursing constitute the major part of the work. The Red Cross service supplements the medical aid offered to wives of enlisted men and noncommissioned officers in all the war services through the Children's Bureau.

One of the outstanding services is that of Vallejo, California. Funds have been provided for a director and five staff

nurses to work among the inhabitants of this town, the population of which has increased from 22,000 in 1940 to more than 100,000 in 1943.

Red Cross Visiting Nurses' Services have been established also at Fort Leonard Wood, and Camp Crowder, Missouri; Fort Sill, Oklahoma; Camp Bowie, Texas; New River Marine Base, North Carolina; Tucson, Arizona; Chico Army Flying Field, Camp Beals, Camp Roberts and Fort Ord Village, California; Spokane and the Bremerton Navy Ammunition Depot, Washington; Camp Beauregard, Louisiana; Camp Blanding, Florida; Camp White, Oregon; Fort Smith, Arkansas; and Fort Benning, Georgia.

- The National Nursing Council for War Service held a conference of state nursing council executives in Chicago, June 17 and 18. Organization and functions of the new Nurses' Supply and Distribution Service were discussed, with special emphasis on the role of state and local nursing councils in its actual work. The status of the Service and the scope of its program awaits government action. The newly established Student War Nurse Reserve was also discussed.

- Announcement has been received of the formal organization of the National Association of Practical Nurse Education, with Hilda M. Torrop (see also page 356) as president; Helen Z. Gill, vice-president; Etta A. Creech, secretary-treasurer. Active members, now 75 in number, include registered nurses engaged in directing or teaching in practical nurse schools

NEWS NOTES

and other instructors and lay persons on boards of practical nurse schools. Associate members include the medical profession and representatives of practical nurse state organizations. Fourteen

states have licensure and approved schools of practical nurse training have been set up in these states. There are, however, good schools for training practical nurses in other parts of the country.

From Far and Near

Recovery of American Wounded—More than 97 percent of naval and marine wounded from Pearl Harbor to March 31, 1943, have recovered, according to the Office of War Information report on the care of the wounded by the medical departments of the Army and Navy issued May 19.

Never before in the history of the world, states the OWI, has the fighting man had available the medical care and equipment the United States now furnishes its defenders. When medical supplies are delayed in reaching the front, American doctors are trained to perform their duties with whatever equipment is at hand. In the North African campaign, ships carrying medical material were torpedoed. Yet a system of caring for the wounded was established right from the beaches of the Mediterranean. The hundreds of recoveries from wounds testify to its effectiveness.

Care of the wounded under the American system of military medicine begins with the soldier himself. Each man has fastened to his belt, easily removable, a first-aid packet, a package of sulfadiazine tablets—an improved member of the sulfa family of drugs—and sulfa powder. If the soldier is conscious after he has been wounded, he begins to take the sulfa tablets immediately. The special package releases them into his hand one at a time. He dusts the sulfa powder into his wound. He uses the first-aid packet.

In all probability, however, a hospital corpsman has reached him before he has a chance to do this. The corpsman has a larger kit of supplies with him and administers quickly to the soldier, giving him an injection of a drug which stops pain almost instantly. Litter-bearers carry the soldier to a mobile battalion aid station from 400 to 1,000 yards back. This station, a miniature hospital on wheels, is staffed by two physicians and assistants. It has operating instruments, anesthetics, sulfanilamide,

opiates to relieve pain, hot drinks, and, most important, blood plasma to combat shock and loss of blood. In the usual case the soldier remains here a day or less, and then is evacuated by ambulance-jeep or other conveyance back to the collecting station. The collecting station is also mobile, and can be brought up as close to the front lines as necessary. Here the various cases are classified so that each man is assured of the exact type of treatment required for his particular injury. From the collecting stations the more seriously wounded are evacuated to mobile field hospitals or evacuation hospitals which are usually some 5 to 7 miles back of the battle line. Farthest back are the great general, or base, hospitals. These are not mobile. They are far removed from the battle area, sometimes several hundred miles. The general hospitals have 1,000 beds or more, and are the equal of the most elaborate city hospitals. The men may remain there until they are entirely cured and returned to duty, or they may be sent by ship or plane to general and convalescent hospitals in the United States.

One unit to which many a soldier owes his life is the mobile X-ray machine. In the last war, these machines, although technically portable, were huge, clumsy affairs; several men were required to haul them from one room to another. The present battlefield X-ray unit can literally go into action with the men.

Reducing Absenteeism—To assist in advising on methods of reducing absenteeism the Division of Labor Standards of the U. S. Department of Labor recently surveyed the experience of 200 outstanding war plants in dealing with this problem. The survey revealed that illness, accidents, transportation difficulties, poor housing, bad nutrition, lack of child care facilities and other problems which the individual worker cannot solve alone are responsible for most ab-

(Continued on page A8)

Visiting Nurse Bag

Adopted by Visiting Nurse Association of Chicago



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News

(Continued from page 421)

senteeism and that wilful absenteeism is almost negligible. Plants had less of an absenteeism problem which required prompt reporting of unforeseen absences. Some had nurses or others visit absentees to offer help, others sent letters, telegrams, or telephoned. Some interviewed returning employees to determine the real cause of absence, then helped to remove it, at the same time impressing upon the absentee that his absence was noticed and his attendance at work essential. Poor production planning and material shortages are a serious cause. Pre-planning work as far ahead as possible helps secure a smooth flow of production, but in case of unavoidable lay-offs, plants have explained to employees why there was no work, and arranged for shifts of crews to utilize unused labor. Other problems relating to absenteeism include working hours, industrial accidents and disease, industrial fatigue, nutrition, indifference to work, personal work patterns.

To solve these problems, plants have re-examined the daily and weekly working hours of employees to assure schedules which will maintain output over a long war period. They have developed strong safety and health programs and improved working conditions to re-

duce fatigue. They have allowed at least 30 minutes for lunch and recognized the importance of a clean place in which to wash up and eat. Some have installed plant cafeterias and lunch carts with nutritious foods. They have encouraged recreation and given vacations, emphasizing by various means the importance of the worker's job to the war effort. Counselling or welfare services have helped adjustment to factory work for new employees.

The survey also considered community problems as causes of absenteeism—transportation, poor or not enough housing, wartime difficulties in conducting shopping and personal business, lack of child care centers, lack of recreation facilities. Many plants have taken a leading part in planning and helping to provide the suitable means of meeting these worker needs.

The details of the survey are contained in "Controlling Absenteeism: A Record of War Plant Experience" available upon request from the U. S. Department of Labor, Division of Labor Standards, Washington, D. C.

Another useful pamphlet dealing with absenteeism is "Guide for Plant Labor-Management Production Committees: Ways of Dealing with Absenteeism as Part of the War Production Drive" issued by War Production Drive Headquarters, War Production Board, Washington, D. C. While designed primarily to aid

PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

World Nursing Unites in the International Council of Nurses

IN THIS ISSUE of the magazine will be found several articles dealing with public health nursing in foreign countries. It seems appropriate to introduce this material by using as an editorial extracts from a thoughtful paper read at the National League of Nursing Education Convention in June by Effie J. Taylor, president of the International Council of Nurses:

At no time in the past have the professional nursing organizations stood more deeply in need of wisdom to deal with the many unprecedented problems with which (at the close of this tragic war) they will be confronted. However, the fundamental points upon which no confusion seems to exist are the functions of nursing to render service to human beings and assuring adequate education to nursing students.

The International Council of Nurses, as a repository for world information regarding the standards of nursing education, nursing activities associated with new knowledge based on advancing science, and opportunities for the development of nursing in all its aspects, now carries a vital responsibility. It must continue its striving to bring within its resources all national nursing organizations which need the cooperative assistance that one like group can afford to another through sharing of experience.

During the first two years of the war, a remarkably good contact was main-

tained among all of the 32 countries. While the United States was neutral, it was possible to carry on correspondence with many countries which were at war. Even during the first year of occupation and until after Pearl Harbor, through one means or another, communication was maintained with the nursing organizations of all the British possessions, China, Japan, the Philippines, Cuba and with the Scandinavian countries, except Norway, and the low countries. Letters received from members of the Board of Directors illustrate what many nurses are accomplishing in spite of overwhelming odds. Contacts with other member organizations in Europe—France, Hungary, Rumania, Bulgaria, Yugoslavia, Poland, Estonia, Czechoslovakia and Greece—have been few. But there is reason to know that the nurses in these countries, as in others, are doing marvelous work. Even when they are tired, cold and hungry, they forget themselves in serving those who must depend on them for comfort and relief. During recent months no official reports have been received from the national organizations in the occupied countries, but personal letters have been received. In a number of these countries nurses are continuing to meet to carry on their professional business which for the time being is largely concerned with their own immediate problems and with giving

(Continued on page 462)

Wartime Impressions from England

By IRENE H. CHARLEY, S.R.N.

THE STAGGERING calamity of war in 1939 produced the double effect of blunting the powers of imagination as to what total war would mean to the civil population and putting into cold storage many of the public health services so carefully built up since the last war. Fear of bombing meant mass evacuation from town to country. Very few public health nurses, however, accompanied mothers and children to their safer refuges. Carefully developed plans for the control of tuberculosis were ruthlessly disorganized, as facilities for after-care in evacuation areas varied considerably from those in urban areas. Priority was given to staffing first aid posts where trained public health nurses kept watch night and day for bombs which during the first 12 months fortunately did not fall. That briefly was the effect of fear on a service which needs faith and imagination for its motive power.

Happily there were restless influences at work urging the Government to remember that total war required total health and that intensive nursing care for mothers, fathers and children was as urgently needed as for the fighting forces. Slowly but surely during that first year the nursing profession recovered from its enforced inactivity and rubbed its eyes as if emerging from a bad dream. Happily too the authorities began to realize that nurses were as gold and would become more precious as the

ever-increasing need for their services became more insistent.

Perhaps the first important change to become obvious was the willingness in official circles to consult with those who knew the practical side of the job. Almost overnight official barriers disappeared and the way was opened for effective cooperation of a practical nature later on. If good can come of war, then certainly in this country it is encouraging that the nursing profession can now give its contribution in a consultant capacity to the national war effort. Nursing experience, because it is based on a philosophy of common sense shorn of all frills and furbelows, was recognized as invaluable in time of disaster when simple fundamental needs for maintenance of health absorb all attention.

And so the first year of war was a breathing space for discussion and planning in readiness for the eventual assault. Credit is due those who battled during that time not only for the re-establishment of our maternity and welfare services but also for a wide development of new services to meet the ever-growing needs.

CHILDREN'S nurseries rapidly became news. Large country mansions took down their fusty curtains and stored in the basements the suits of armour which had kept guard on the stairs for centuries. Happy shouts of London children brought new life to these ancestral

IMPRESSIONS FROM ENGLAND

halls. Huddled nurseries made their appearance on the grounds. More and more children frolicked in the free air for the first time in their lives and took lessons in healthy living under the care of specially trained nurses and teachers.

Women's organizations became more vocal and unceasingly called for more nurseries. Mothers were being drafted into industry to feed the insatiable war machine. How could they leave their children? Here was a challenge to the married nurse with children of her own. She readily responded to the call for staffing the nurseries and her small family could go with her to work. The familiar criticism that the nurse trained in curative work was not the best equipped for the care of well children was quickly recognized by the nurses themselves, who asked for post-certificate training in child care. The advice of the child psychologist was sought and study of the normal child created a new interest. The possibilities of giving a foundation in mothercraft to large numbers of young girls who were employed as nursery nurses opened up many new experiments in training. Sceptics shook their heads and questioned the establishment of such elaborate nurseries which would be of use only during wartime. People with imagination, however, thought of the future when the short-stay nursery would become an integral part of health services and provide relief for the sick or tired mother. Public health nurses saw an opportunity here for giving a basis of sound training in the care of the well child so often lacking from hospital training.

IT WAS soon evident that the factories of the country would need countless nurses. Through the wide vision and sympathetic understanding of our great Minister of Labour, Ernest Bevin, the Royal

College of Nursing trained more and more and still more industrial nurses. Financial grants from Treasury funds met the whole cost of fees and subsistences for the nurses selected for this training. Unfortunately the urgency of the wartime demand made it necessary to shorten the courses to three months. Even so the supply cannot be said to meet the demand, as it is now obligatory on all employers who are so instructed by the Ministry of Labour to provide both a medical and nursing service in their plants. A noticeable feature has been the entry of hundreds of private duty nurses into factory life where they are finding satisfaction in their interesting new work.

The development of the scope of the industrial nurse has been almost phenomenal. Because the entry of millions of women into industry has created as many new problems, the industrial nursing service has become a popular aspect of factory life. A service which in 1939 had few standards and little uniformity is growing steadily and assuming a form which to those who are helping to shape its destiny is surprisingly complex in character. Recently the Ministry of Labour said "the care of the industrial worker's health is both an art and a science." Full well does our profession appreciate how true this is. Now in the fourth year of war, when weariness and industrial fatigue begin to take their toll, the art of industrial nursing becomes more evident.

Here a tribute must be paid to the district nurse who is so closely identified with the industrial nurse. Early in the war she was told that she would be a second line of defence in these small islands and valiantly she has carried on. In many districts she visits all employees who are absent because of sickness or injury. The doctor may have diagnosed

"nervous debility" or "industrial fatigue," but it is often the district nurse's privilege to find out the real cause of the absence. An example illustrates this point. Two women engaged in part-time factory work who were frequently absent were referred to the district nurse. Both unburdened their feelings of unhappiness to her sympathetic ear. They felt they were not wanted because they could not give a full day's work. No one had invited them to the canteen for full-time workers or made them feel they were a real help to the war effort. They weren't fussy, but they would like a kind word! The district nurse had diagnosed the root cause of the trouble. She tactfully transferred her observations to the labour manager at the works who knew how to put the matter right. Yes, nursing is truly an art as well as a science.

The insatiable demand for knowledge and opportunities for discussion among the industrial nurses shows that impact with the outside world has done much to mould character and broaden sympathies. They now take their place on production and safety committees, advise local boards dealing with manpower and represent the work people on some of their community committees. Gone are the days when only first aid was considered the industrial nurse's function. She is now responsible for a wide health program which includes all those activities centering in an industrial social service department.

The organization of the industrial nurse is a matter of continual discussion. As a member of a team of public health nurses she is eligible for membership in the Public Health Section of the Royal College of Nursing. Her presence there has been a stimulus to more orthodox thinkers. Some feel this virile new group would find better scope for expression in a group outside the Public Health Section. Each specialist branch has a valu-

able contribution to give to the whole so that it seems most desirable to keep the team unbroken as long as provision is made for minority interests.

AT THE present time there is an unmistakable indication that the nursing profession is seriously considering a more closely-knit organization and the need for group action. Membership of the Royal College of Nursing is rapidly growing. The Student Nurses Association is exerting a real influence as student nurses begin to realize they cannot learn too soon how to manage their own affairs. It is noticeable in any meeting of nurses that the younger ones are learning to express themselves with dignity and grace. Recently a student nurse was congratulated by the deputy leader of the House of Commons for her contribution to a debate on the question of equal compensation for men and women suffering from war injuries. This brings to mind that the nursing profession has in the brief period of war shown its willingness to abandon a policy of isolationism and is now playing a larger part in women's affairs generally. No longer can it be said that the attitude of the nursing profession is responsible for holding the women's movement back a decade. For years the profession had asked for nurse representation on official bodies responsible for working out professional plans. For years this simple logical right was withheld, until the stimulus of war emphasised the wisdom of the nurse's claim.

This stimulus has received its appropriate reaction throughout the entire profession. An obvious desire is expressed through the Student Nurse Association and the organized branches of the Royal College of Nursing for nurses to take a more active share in managing their professional affairs. It is encouraging to realise that the democratic

principles for which we are fighting are thus being jealously guarded in the profession. That leaven is working among the whole profession was indicated soon after the outbreak of war when the economic position of the nurse needed investigation. Accordingly the Minister of Health appointed a Nurses Salaries Committee under the chairmanship of Lord Rushcliffe. Its terms of reference were:

To draw up agreed scales of salaries and emoluments for State Registered Nurses employed in England and Wales in hospitals and in the public health services, including the service of district nursing, and for student nurses in hospitals approved as training schools by the General Nursing Council for England and Wales.

Two panels were set up, 20 on each side, the members being appointed by various organizations representing employers, nurses and the organized profession itself. The value of organization was immediately shown, as the Royal College of Nursing was allotted nine seats. For months an exhaustive inquiry was made of nursing conditions. A national scale of salaries was agreed upon and recommended and it is now in process of being adopted. For the first time there will be a minimum salary scale for nurses throughout the country. One important point which emerged was the fact that employers realised the need for standardization of teaching qualifications in the training schools. When it is pointed out that scales had to be made to cover 17 grades of matrons in various types of hospitals, the intricacy of the question does not need comment. To date only the scales for hospital nurses have been settled. There still remain the large groups of public health nurses working for local authorities, voluntary associations and elsewhere and an additional report is expected shortly.

SHORTAGE of nurse power rapidly became more serious as war progressed.

Other women's service organisations, it was thought, were attracting girls who might otherwise enter the profession. The nurse power of the country was not known as no registration had been made. Consequently, all "nurses" were required to register on one day in April. The results are now eagerly awaited.

Registration, of course, presupposes some form of direction. Once more the Government has asked the profession to advise them on the best possible way to use the nurses who are available. Therefore a National Advisory Committee for the recruitment and distribution of nurses, on which there is a substantial nurse representation, was set up by the Minister of Labour. Whether hospitals or preventive services should have priority will no doubt be among the first questions to be considered.

Another problem this country has to face is the provision of an adequate midwifery service. Difficulties grow no less in providing this service as the birthrate continues to mount. Midwifery is largely practiced by specially trained nurses so that many of them must be reserved for this important branch of public health nursing.

Nursing legislation has been in the news, for a Nurses Act has been passed. Its object is to legalise the status of the assistant nurse who for years has done splendid work in the hospitals caring for the chronic sick, the aged and infirm. Enrollment of this grade of nurse will be carried out by the General Nursing Council, which will be responsible also for establishing standards of instruction and examination. Such legislation is long overdue and is the result of unceasing demands from the nurses themselves.

THE profession is not concerning itself only with its immediate needs. It is looking ahead to reconstruction, always

PUBLIC HEALTH NURSING

an interesting subject for debate. War has brought about a fluidity of thought and an encouraging receptiveness to new ideas. Nursing administrators are willing to accede to the demands of nurses for a more comprehensive general training embracing experiences in all the services including additional public health work in homes.

Through the munificence of Lord Nuffield, a great industrialist, vast sums of money are being set aside for the establishment of chairs of social medicine within the universities. The public health nursing profession envisages its training logically centered in these schools, where the emphasis will be on the preventive rather than curative aspects of disease. Public health nurses have always felt the lack of facilities for studying the patient in his normal surroundings—his home and his place of work. This should be corrected when the new school of thought is accepted.

How to maintain and increase the supply of public health nurses is a problem causing some concern today. The time necessary for post-certificate training in public health is an inhibition to many suitable candidates especially as girls now often need to become economically independent of their parents as early as possible. Opportunities for obtaining financial assistance in public health training are rare. The demand that the State take more responsibility for the education of nurses who will teach positive health is growing more insistent.

THE public health nurse realises that great fields will open up before her when the new world is born. Through the Beveridge Plan for social security new avenues for social service will develop. A comprehensive medical and nursing service is already being planned, but the giants—Want, Disease and Squalor—will still be nurses' chief ene-

mies unless they are banished by the Beveridge Plan. With a nation awake to the fact that health education can produce miracles if teachers are available and insecurity no longer a paralysing influence, opportunities for nurses will surely be unlimited.

Already the campaign for health education is in full swing. Young people are organised into either youth organisations or pre-service and service groups. Women are congregated together so that group teaching becomes more practicable. The profession is suggesting that a new kind of public health nurse is urgently needed with special preparation in educational psychology and principles of teaching. Nurses able to teach not only in the homes by demonstration but also in clubs or other organisations where their services are required will find adequate scope for their skill. Plans for continued education will probably suggest opportunities for health teaching among adolescents whose health needs have unfortunately been ignored in the past.

There are many other new worlds to conquer. Venereal diseases and tuberculosis which raise their heads so regularly during wartime both challenge the public health nurse.

AS ONE of a team of health workers she is reorienting her ideas. She admits the need for some dilution among her ranks. She recognises the place of the assistant nurse in certain public health fields where routine clinic work can safely be deputed to her. She claims, however, that the assistant nurse should not be given full responsibility but should always be supervised by the state registered nurse. Members of this team are becoming more aware of their respective functions. Broad changes in training for social work are being freely discussed. Large numbers of civil serv-

INTER-AMERICAN NURSING

ants who will administer any new social security scheme recognize they need such training. The field continues to widen as the team takes on more workers. But the public health nurse is in-

sistent that she maintain her place in the home as the pivotal point, a place she holds uncontested because of her intimate relationship with the family unit.

JOINT COMMITTEE ON INTER-AMERICAN NURSING

AT THE meeting of the Board of Directors of the American Nurses' Association held at Chicago, June 13, Mary Elizabeth Tennant, chairman, presented the following report for the Joint Committee on Inter-American Nursing:

In December 1941, representatives of the three national nursing organizations, American Nurses' Association, National Organization for Public Health Nursing and National League of Nursing Education, met to discuss the question of organizing a committee that would interest itself in inter-American nursing. As various American organizations are interested in bringing nurses from Latin American countries to study in North America, it seemed desirable to organize a joint committee to facilitate study programs so that everything possible might be done to make the nurses' stay profitable and pleasant. The following were appointed to the Joint Committee: Naomi Deutsch, chairman; Alta Elizabeth Dines, co-chairman; Mary Alberti, secretary; Mary Roberts; Sister M. Olivia Gowan; Mary Elizabeth Tennant; Adelaide Mayo; Julia Stimson; Effie J. Taylor; Katharine Faville; Ruth Houlton, ex-officio; and Alma Scott, ex-officio; Ernestine Wiedenbach has recently been made a member.

Miss Deutsch, as chairman, wrote to the State Department, the Pan American Sanitary Bureau and the Office of the Coordinator of Inter-American Affairs to inform them about the committee and offer professional advice, if it was desired, concerning the development of nursing. She also offered assistance to Latin American nurses coming to the United States to study. All of these organizations sent immediate replies, welcoming the assistance of the committee. During 1942 six meetings of the Joint Committee were held, and three meetings thus far in 1943.

In order to advance the development of pro-

fessional nursing in Latin America, the Joint Committee felt that it would be useful to have two or three motion picture films made which would stimulate interest in nursing as a profession here and depict good nursing procedures. A film committee was appointed and has been working with representatives from the Office of the Coordinator of Inter-American Affairs. Two films are now being made by the Emerson Yorke Studio, with Helen Faddis acting as professional adviser, and the Joint Committee giving assistance whenever called upon. The first film is documentary, portraying the different fields of nursing. The second shows the preparation of a professional nurse and may be used for recruiting purposes in Latin America. Both are silent, but running commentaries will be made in Spanish and Portuguese.

A book committee, with Ruth Houlton as chairman, was appointed to prepare a list of books recommended for schools of nursing and public health organizations in Latin America. The question of translating important books into Spanish is being studied.

Advice has been given by Joint Committee members regarding the selection of some of the North American nurses sent to nursing projects in Latin America by official agencies. At present there are North American nurses working in Brazil, Argentina, Paraguay, Bolivia, Chile, Peru, Ecuador, Colombia, Venezuela, Panama, Guatemala and Haiti. In addition to financing the films the office of the Coordinator of Inter-American Affairs has given financial assistance to the development of nursing education and public health nursing in Brazil, Paraguay, Bolivia, Chile, Peru, Ecuador and Colombia. Miss Deutsch has joined the staff of the Pan American Sanitary Bureau and has made a tour of Mexico, Central America and Venezuela; shortly she will go to Guatemala. Because of Miss Deutsch's absence from the United States, Miss Tennant has been appointed chairman of the Joint Committee.

Public Health Nursing in Lebanon

By VIOLA E. CARDWELL, R.N.

PUBLIC HEALTH NURSING with the American University of Beirut in Lebanon during the years 1938-1941 included a varied program which became increasingly diversified as the effects of war brought additional demands for service. Work was carried on in a number of greatly dissimilar settings including a modern health center in Beirut; a large Bedouin camp on the plains; improvised refugee shelters on the outskirts of the capital; an evacuee town over the Lebanon Mountains; the out-patient department of the University Hospital; temporary summer clinics in Sheikhs' houses; classrooms of the nursing school; and an auxiliary military hospital unit for the French troops.

The office of the director of public health nursing was in the out-patient department, which was an important clinical training field for the Medical and Nursing Schools. Supervision of this unit and clinical teaching of the nursing students were included in her duties. Insofar as a limited staff would permit, health teaching and an awareness of the public health aspects of disease were incorporated in the work of every clinic. Through the out-patient department patients were admitted to the hospital. They suffered from a variety of sub-tropical diseases such as numerous parasitic infestations of the intestinal tract, dysenteries, oriental sores, sand-fly fever, the all too common malaria and typhoid, and an occasional case of typhus. A few cases

of leprosy and other rare skin diseases were treated only in the clinic. These patients also suffered from most of the diseases common to the northern United States. The patients may not have been more varied in nationality than in a clinic in New York City, but their attire was decidedly more striking. Among the city Moslem women, whose heads and faces were entirely obscured by black shawls and heavy veils, were interspersed peasant women in gayer garb whose heads were covered only with white kerchiefs and whose faces were almost completely unveiled. The city men of means looked sophisticated in their foreign clothes topped by a black-tasseled red tarboush (fez), beside the men from the plains in their flowing gowns and white kefeyeh. In every group, there would also be a few Bedouin in their voluminous robes, a beggar in rags and maybe some shepherds from the mountains, all lending color to the numerous Armenians, Assyrians and Arab Christians who wore less characteristic garb.

THE maternity and infant health centers were also located in the out-patient building. Home visits were made to Health Center infants and children and to all prenatal patients living in the area. A home delivery service was provided, but, due largely to poor home conditions, the majority of patients were delivered in the hospital. The clinic nurse also had charge of the home delivery service and

NURSING IN LEBANON

field work. New babies were transferred from the maternity to the infant health station at the end of the third week. The doctors who served in the maternity clinic also had charge of the hospital service. Thus, there was a continuity in the medical and nursing service throughout the entire maternity cycle, provided the patient came early in her pregnancy. Too many patients, however, registered just in time to make arrangements for their confinement.

The nursing students came, or, in many instances, were sent by their respective governments to the American University of Beirut from Cyprus, Iraq, Iran, Palestine, Transjordan, Egypt and other nearby countries as well as Syria and Lebanon. There were always plenty of applications from qualified Armenian and Jewish girls, but very few from Arab girls of Syria and Lebanon. Of those Arab students who came, 99 percent were Christian. About 75 percent of the patients were Moslem. Although education is having some influence, the Moslem tradition of secluding their women has not yet been sufficiently broken down for nursing to appeal to that group as a profession. The consequent dearth of well-trained Moslem nurses has made the expansion of health work slow. Only time, education, perseverance and patient endeavor will change the status of women in the Moslem world and free them to take their part in helping relieve and prevent suffering, disease and distress.

TO REACH the two rural clinics in the Bakaa plain between the Lebanon and the Anti Lebanon ranges it was necessary to drive for nearly two hours over the Lebanon mountains on the Beirut-Damascus highway which has almost continuous precipices and hairpin curves. In the daylight and in summer this was a very beautiful drive. But at night when the



An Arab mother bathes her baby according to instructions received at Health Center



Six thousand villagers of Musa Dagh, once more evacuees, set up tents in Lebanon



Eye infections were so prevalent, evenings still found patients crowding the clinic

PUBLIC HEALTH NURSING

road was completely enveloped in fog, and in winter when snow blocked the pass, this trip at the end of a hard day's work was sometimes an ordeal. Nor was it pleasant to arrive back in Beirut alone at nine or ten o'clock at night when complete blackouts were enforced. To get out of the public car in the heart of the city and find the way up to the college in pitch darkness through the jostling crowds of Arabs and French Colonial troops who represented a composite of Moroccans, Algerians, Madagascans and French sailors was the final touch to a long hard day's trip.

One of these health centers over the Lebanon Mountains was being conducted as a demonstration center by the Near East Foundation in a typical isolated Moslem village. Residents there were almost wholly uninfluenced by modern civilization. They carried on their lives and farming just as they had done for centuries according to the teachings of Mohammed as set forth in the Koran. The Health Center was trying to improve the health and living conditions of these people in every way possible through a generalized service but with special emphasis on infant and child welfare. Here a Lebanese nurse, Hilda Hakkim, graduate of the American University Nursing School and of the Vanderbilt University course in public health nursing, held a daily treatment clinic and conference on infant care and other problems of sickness and health. Another function was to teach the village midwives the necessity for cleanliness and for calling a doctor in case of complications. Periodic immunization clinics were also held. Once a week a pediatrician from the Beirut Health Center made the trip over the mountains and saw all the patients for whom the nurse had made appointments.* At the close of the clinic he and the nurse would visit any patients too sick to come to the clinic,

and, as often as possible, would drop in at the store where the men congregated or at the home of the Sheikh of the village. Here they would teach sanitation and hygiene and try to interest the villagers in drilling deep and properly enclosed wells until such time as they could afford to have a safe water supply piped in from the mountains.

Handicapped by inadequate medical service and funds and an appalling disinclination on the part of the Moslem villager to change any of his customs, since everything, good and bad, is from Allah, progress at this center was not rapid but some evidence of improvement was definitely seen. A certain number of privies became evident in the village where none existed before; houses grew noticeably whiter and cleaner than in surrounding villages; babies became cleaner and much better cared for; and their cradles, though not the houses, were screened against the malarial mosquitoes and flies. Statistically, it was hard to prove anything very conclusively in a "before and after" manner, since there were no figures obtainable for infant deaths prior to the establishment of the center, but the infant mortality rate decreased considerably during the first four years that the demonstration was in progress.

WHEN FRANCE, possibly to ensure a friendly neighbor on her north, gave back the control of the border area between Lebanon and Turkey, known as the Sanjak (Alexandretta), to Turkey just prior to the outbreak of war in 1939, 6,000 Armenians left this area and migrated to Anjar in Lebanon. They were given guarantees of assistance in rehabili-

*Now a full-time resident physician for the Bakaa Health Centers has been stationed in that area by the American University to eliminate necessity for travel and to give more continuous service.

NURSING IN LEBANON

tation provided they kept together as villages and went to an area assigned them by the French Government. The five villages surrounding Musa Dagh (of "The Forty Days of Musa Dagh" fame) were located at Anjar on good farming land with an excellent natural water supply. This supply had once been canalized in Roman aqueducts but was now running at will, creating swamps and a hot bed for malarial mosquitoes. Here were 6,000 men, women and children set down on a plain with nothing to live in but tents improvised of unbleached muslin, far from other villages large enough to supply food for so many people and with toilet facilities consisting only of an open trench. Needless to say, there were many health and sanitation problems. The High Commissioner of Lebanon asked if the workers from the Health Center would help with some of these problems. We inoculated the refugees against typhoid fever, worked to control the eye infection which had spread throughout the camp, and assisted the French army doctor in caring for the high incidence of disease which inevitably developed.

Gradually a new town started to emerge as house after house replaced the tents of the refugees. In the spring of 1940 construction work was started on a clinic building. This was not completed until fall, owing to considerable disorganization resulting from the capitulation of France with its ensuing upheaval in the government of Lebanon, the coming of the Italian Commission and the British blockade. When it was completed, we had a very shipshape little clinic, unusually attractive in its fresh paint amongst the earth-colored, one-roomed houses, but it was far from being adequate for the crowds who came. This was the center for all our activities. They were basically the same as in the Moslem village, except

that here we added a milk station because it seemed of little use to give medical care to children and wear ourselves out trying to get sufficient drugs for them when they all had one fundamental complaint—slow starvation.

ON THE DAY that the writer took what proved to be her last trip to this camp, she had many contacts among the refugee leaders. The camp, then a town released of military control, had recently been given its autonomy and had just elected a mayor. Hearing the director of public health nursing was visiting, the mayor, the religious leaders of the town—including the Gregorian, Maronite and Catholic priests and the Protestant minister—arrived to discuss the work with her. The voluntary testimony of the priests as to the results of the clinic was very gratifying. One said, "Since you started the clinic last fall I have scarcely been called on to bury a baby and prior to that time it was almost a weekly occurrence." Another spoke up and said, "Neither have I been asked to bury one. The difference is amazing." Each was eager to do everything in his power to help us continue effectively and, with the mayor, planned specific ways and means by which they could assist.

Directly after this conference the first R.A.F. planes were seen and heard bombing the nearby French airport of Ryak which was harboring German planes. It was the next morning, May 16, that we received word from the British consulate that it would be wise for the British to leave the country at once. We immediately delegated all the various branches of work, with the budgets and accounts, to the people who would be in a position to carry on; quickly closed up our homes, and packed sketchily for a journey of indeterminate length and

PUBLIC HEALTH NURSING

route. Soon we were on our way along the beautiful Mediterranean road through Tyre and Sidon, crossing the border into British-ruled Palestine before the Italian Commission and the Vichy French Government decided if, and how, they should retaliate. In a few days most of the

American women and many of the men also crossed over into Palestine. Ten days later along that same road the battle for the control of Lebanon was bitterly fought between Free French and British troops on one side and the Vichy-dominated French troops on the other.

LETTER FROM PERU

Tingo Maria, Peru

March 26, 1943

I know you will be interested to hear that the public health situation in this tiny spot is in hand. After a series of convulsions, the hospital has taken form and is functioning smoothly. We have 9 men in our 10-bed men's ward, 1 in a private room (a policia), women in their ward, and 2 children in their own little 6-bed ward. In addition, we have a flourishing out-patient clinic which takes care of between 40 and 50 patients a day. The people are gentle, affectionate, and so willing to cooperate.

Peru has changed little from the days of the conquistadores, and I know that Pizarro would feel as much at home now as he did in the sixteenth century. It seems to me that the greatest need for change is in the food habits of the people. I feel so much can be done with small children. Habits and customs of adults are almost impossible to change. I would like to see food stations established in every town where there are 50 or more children. If in addition to two proper meals a day, children could have clinical treatment when necessary, perhaps in

10 years or so Peru would have a healthy young race. The food of the average adult—and child—is potatoes, rice, and fideos (macaroni in fancy shapes). I have everyone at the hospital—doctor, nurses, employees, patients—eating carrots twice a day.

We have two Peruvian nurses here. One, Señorita Acosta, who will be head nurse, has been out of school about 13 years; the other has graduated within the year. Both are from the British-American Hospital in Lima, and have had a splendid nursing education. This hospital is manned by Americans and has a training school for about 60 students that is the best in Peru.

Our next project is in Pucallpa—a malaria country. We are fortunate here, having no malaria at all. There is no typhoid either, and that, in spite of there not being a single latrine in the village where perhaps 300 or more people live. All bathe, do their laundry, and drink from the river.

HELEN FLANAGAN, R.N.

DIVISION OF HEALTH AND SANITATION
OFFICE OF THE COORDINATOR OF
INTER-AMERICAN AFFAIRS

Placing the Discharged Patient

BY HOLLAND HUDSON

TO SOME of us it seems but yesterday when one of the chief problems confronting an arrested tuberculosis patient was where he might find suitable employment. Even now when a manpower shortage has made jobs less difficult to get in most production areas, the problem of finding a *suitable* job has increased rather than diminished. Some employers whose personnel workers consult industrial physicians and nurses are making highly intelligent and suitable placements of all types of physically handicapped persons. Others who "hire at the door" with no regard for medical history are increasing the hazards of arrested tuberculosis patients by assigning them to jobs for which they are not ready. As every public health nurse is aware, the hazard involves not only the patient himself but also, if the unsuitable assignment helps to reactivate his disease, his family and his associates who may become infected.

Often the public health nurse can do much to protect the patient and thus the family and the community from such hazards, particularly if she makes use of facilities which have been established for such purposes. Hundreds of relapses following treatment for pulmonary tuberculosis may be traced to inadequate information on the part of the patient and his family. Many tuberculosis institutions today do a thorough job in preparing patient and family for the problems which follow discharge. But war recruitment and the competition of war produc-

tion have left many sanatoria so understaffed that they are literally unable to prepare the patient, much less his family, for what he must encounter outside the institution. Therefore, frequently he has never heard of agencies which can assist him in finding his way to suitable employment and even provide training for such employment. Occasionally he has heard of such aid but has been talked out of making application for it by his family who are incredulous of anything on which they do not have direct information.

THE NURSE will begin, very naturally, with the question of how much the patient has accomplished toward the conquest of his disease. If he is still an active case, he is unfit for any kind of employment and has the capacity to infect others in the home or on the job. It is the responsibility of the health worker to induce him to complete treatment until his medical advisors pronounce him ready for a specific type of employment. Often this involves persuading his family in order that they may encourage and support his decision to follow competent advice. Death rates from tuberculosis would drop very substantially if more patients would complete their treatment instead of bolting as soon as acute symptoms have receded.

As a number of institutions have demonstrated, unsuitable employment may contribute to the reactivation of the disease but suitable employment may be-

PUBLIC HEALTH NURSING

come the final contribution to successful treatment. What jobs are suitable for persons with a history of pulmonary tuberculosis? The answer that no two cases are alike and that each case calls for individual solution is medically accurate but irritating to those who seek shortcuts. People without hospital and clinical experience seldom realize that every step in the diagnosis, treatment and management of pulmonary tuberculosis presents an individual problem. Therefore it is natural for them to seek categories of jobs suitable for persons with inactive tuberculosis and other physical handicaps.

The Federal Civil Service Commission published a 211-page mimeographed inter-office memorandum, based upon studies of a number of government establishments and industries manufacturing war materials, which listed jobs suitable for selected applicants with a history of tuberculosis. This publication has been exceedingly valuable in opening up jobs for the physically handicapped in a number of industrial organizations, because the Federal Civil Service Commission handles the largest personnel procurement service in the country. A number of large industrial employers, notably Lockheed, followed with categories of their own. The National Association of Manufacturers issued Bulletin No. 45, urging employers to meet the manpower shortage by placing physically handicapped persons, including the tuberculous, in suitable jobs.

The United States Employment Service, after substantial experience in placing the handicapped, has taken another forward step. Convinced of the need for individual study of job and applicant, this service is evolving a Physical Requirements Form for job analysis which seeks to identify those elements or work conditions in a job which make it suitable or unsuitable for a physically handicapped

applicant. By means of this form the placement officer may learn whether the job requires the applicant to work indoors or outdoors, in high or low temperatures, in dust, in daylight or artificial light, to walk, stand, sit, lift, stoop, push or pull, and so on. The interviewer who matches up this form against medical description of physical limitations and necessary precautions will be the more likely to achieve suitable placement.

This brings us to one of the problems which have confused not only the discharged patient, but also the doctor, nurse and others who have attempted to aid him. The requirements and conditions of most jobs have changed so much and so rapidly that most of us who are not active in the front line of current employment placement are not only uninformed but misinformed regarding the duties which attach to a job name and conditions under which they are discharged. Technological change, which once waited upon the promise of additional profits, has been almost incredibly accelerated. Many of yesterday's exhausting hard labor jobs are today items of machine tending. A number of long-time crafts have been broken down into series of simple machine operations which can be taught to novices. Conversely the hours and energy required for some other jobs have been stretched far beyond their original measure. Thus attempts to counsel the patient without expert information from employment or rehabilitation fields may become not only futile but hazardous.

UTILIZATION of qualified sources of information may also eliminate such meaningless directions as "light work." The collection of specific facts about a specific job enables the physician to relate this information accurately to his knowl-

PLACING THE DISCHARGED PATIENT

edge of clinical findings and probable work tolerance. The mere name of a job without such specifications is no more help to the doctor than "light work" is to the placement interviewer.

Many of the offices of the United States Employment Service are prepared to aid handicapped persons who have marketable skills to find suitable jobs. Here the nurse can play a very definite role by means of a little advance planning with the manager of the nearest public employment office. She should learn from him to which person or division handicapped applicants should be referred in order to get placement suitable to their disabilities. She should refer only patients whose physical restoration is adequate and who have marketable skills. Public employment offices can do nothing for the unemployable.

For those handicapped persons who lack marketable skills or whose previous jobs are contra-indicated medically, the state vocational rehabilitation services, usually attached to the state departments of education, may be able to provide training and subsequent placement suitable to the physical limitations of the applicant. Many of these services have already had substantial experience in serving clients with a history of tuberculosis. The Federal Vocational Rehabilitation Bureau which administers the matching funds which made possible the present volume of this work has definitely encouraged service for eligible and feasible inactive cases. After consultation with some of the country's outstanding phthisiologists, a special medical information form (R-3a, Revised 1940) has been devised and a manual prepared for the instruction of supervisors in its use.

The topic of workmen's compensation turns up now and then to plague those of us who are attempting to aid the recov-

ered tuberculous patient. In point of fact, the amount of money paid out by employers as compensation for tuberculosis, whether contracted or reactivated in employment, is almost negligible especially when compared with the amounts collected for first injury usually resulting from accident. Quite a few close observers of placement of the disabled have arrived at the conclusion that references to the compensation law are frequently used as a smoke screen by personnel men who have a fixed antipathy to certain or all types of disability. The fact is that insurance carriers have placed no additional burden upon employers who take on workers with a history of tuberculosis. Now and then an officious local representative has protested the employment of disabled persons. Such situations can usually be remedied by correspondence with the home office of the insurance company. The public health nurse will be well advised to learn what experience the vocational rehabilitation supervisors and managers of the United States Employment Service have had in the areas which she serves. Oklahoma is one of the first states to study and revise workmen's compensation legislation in order to work less theoretical hardship upon both the employer and employee.

THERE are several very specific ways in which the public health nurse may, by using the state services, promote and expedite further service for suitable applicants with a history of tuberculosis.

1. She should read the regulations which apply in her state until she is quite clear about which cases are eligible for service.

2. She should know the case supervisor who is responsible for the area she serves and should learn his interpretation of "feasibility."

PUBLIC HEALTH NURSING

3. She should refer to this case supervisor cases apparently eligible and feasible for service and *only* such cases.

4. She should explain to postponed applicants the additional time, healing or information required to make them eligible and feasible.

5. By reason of her clinical affiliations she can often assist in the preparation of the detailed medical information called for on Form R-3a Revised 1940 and prepare it for the prognostic opinion and signature of the physician. She should promote personal discussions between the physician and the rehabilitation supervisor and not allow any paper work to form a pretext for by-passing this valuable exchange of direct information.

6. She can often use the story of the state vocational rehabilitation services to encourage the families of patients under treatment when the prognosis appears favorable. She should make it clear that these are not charities, but tax-paid services comparable to public education or public health service.

In addition to using these employment and rehabilitation services, public health nurses in a number of states will find they can secure help from home demonstration agents attached to the state and county agricultural service. Many of these workers can and will aid the rural housewife who has been a tuberculous patient to work out step-saving methods when she attempts to resume her housework. It should be remembered that the homemaker is not now eligible for service from other agencies. For example, every nurse knows there is a way to make beds which not only is more comfortable for the occupant but also saves steps and other lost motion for the bedmaker. She knows

that such skills can be taught. Why not by such means help to cut-down the frequent readmission of housewives to so many of our sanatoria?

BESIDES THE official agencies there are voluntary agencies which have pertinent information and some of which employ special personnel. More than 600 state and local organizations affiliated with the National Tuberculosis Association have such information and a number of them have workers especially trained to aid and counsel the discharged patient.

Everyone interested in the discharged patient finds himself willy-nilly in the role of educator. The patient and his friends encounter a jungle of misinformation. Sometimes the patient or his family grossly misapprehends the employment implications of his history. A few rehabilitation agents are not quite clear about the stability of well-established pneumothorax. Some industrial personnel people have something to learn about the excellent record of thoracoplasties. The better the educator's equipment, the better the results she may expect to achieve.

Nurses can invite rehabilitation and placement workers from official or voluntary agencies to their meetings, can obtain literature from both sources, and can attend tuberculosis meetings in which rehabilitation is a program item. Country-wide, substantial progress has been made on behalf of the discharged patient in the last decade. Some public health nurses deserve a substantial share of the credit for this progress. What they have done should encourage their colleagues to do more in this decade of the war and its aftermath.

Home Nursing Service for the Industrial Worker

BY BERNARDINE STRIEGEL, R.N.

OUR COUNTRY has been hit with a wartime industrial boom unparalleled in its history. To each one of us, in whatever capacity he is engaged, has come the challenge to make the good better and the better best in the race to meet our country's needs. With every resource of manpower and production at our command, it is more important than ever for all of us, especially industrial workers, to remain on the job and keep in condition to do the best type of job possible.

With the value of home nursing to the industrial worker and his family in mind, nursing organizations are studying their services to determine whether or not they are meeting his essential home nursing needs, and at the same time reducing to a minimum any non-essential services. They are reviewing the firms with which they have home nursing contracts, either directly or through an insurance company, and analyzing the service given. So far, the findings indicate that some firms use the service well, others use it to excess, others do not use it at all. As a result, many nursing agencies are asking for suggestions and assistance from the insurance companies which make use of their home nursing services on a contract basis.

In an attempt to give needed help, the Welfare Division of the Metropolitan Life Insurance Company has carefully re-

viewed the amount and type of nursing service which has been given to its Group insured firms. It has found that with some exceptions from 20 to 30 percent of Group insured firms in an average nursing area use this service in the course of a year; about one half of this 20 to 30 percent use it every month; the remainder use it at irregular intervals. An analysis of the list of Group insured firms in an average area would show the proportion using service to be not unduly low since it usually includes most of the firms with the largest number of employees. Many of the remaining firms are branches or subsidiaries where the number of employees is small and, therefore, the volume of illness is negligible. However, some fairly large firms are not using any nursing service at all.

The type of case referred for nursing care varies markedly. An analysis of such cases among employees of the Metropolitan Group insured firms shows that in 1941, 25 percent received some sort of nursing care or treatment; 50 percent were given health instruction; 25 percent were "not found," "not home" or "no service needed." On closer study, it was found that the 50 percent who received instruction only were not all minor disability cases. Many could have used nursing service if the nurse had been called earlier. In the "not found," "not home"

and "no service needed" cases, the majority fell into the "not home" classification. Some of these employees had gone to the doctor's office; others had returned to work; others were out for other personal reasons.

From this brief analysis it is evident that some Group insured firms use the service more than others; some insured employees receive care promptly; a goodly number are referred too late to receive satisfactory or effective service; many are referred when they are absent from work for reasons other than disability. It takes little imagination to see that without using more and maybe not as much nursing time, essential service could be given if the energy now used on "absent" and unproductive visits could be spent on reaching the really ill or injured employee promptly.

CONSERVING NURSING TIME

How can this essential nursing service be provided and non-nursing services reduced to a minimum?

The solution requires mutual understanding and cooperation on the part of the employer, the employee, the nursing organization and, if the firm is Group insured, representatives of the Group insured firm. This implies that the employer and employee shall understand what professional home nursing service is, and how and when to request it; also that the nurse shall give a quality of service which will leave the patient with the confidence and knowledge he requires to use the service effectively in the future.

Three ways by means of which the nursing organization helps to bring about this mutual cooperation are (1) the amount, type and quality of service which the nurse gives to the employee (2) the kind of report which the nurse sends to the firm following her first visit to the disabled employee and (3) the effective-

ness of visits made by the nurse to the firm.

SERVICE TO EMPLOYEE

The service which the nurse gives to the disabled employee depends primarily on how promptly she is called. If this is early in the course of the illness, she can give skilled care when the patient really needs it. Under these circumstances, he will not have to be urged to call the nurse directly and promptly the next time and he will not hesitate to tell his fellow workers to use the service. If, on the other hand, the patient is convalescent or up and about when the nurse makes her first visit, usually no care is given or required. The challenge for the nurse on this type of visit, as in all first contacts, is to become acquainted with the family and explain what her organization is and how the nurse can be of service in the future. She must make sure that the family understands how to call her directly and promptly the next time nursing service is needed. Unless this is made clear, neither the patient nor the family realizes the value of professional nursing service. In fact, they may be suspicious of the motive of her visit.

When the patient is "not home," "not found," or "not ill," the visit usually is not only unproductive, but also it is likely to create antagonism toward the nurse and the employer. Even though the nurse utilizes the opportunity to give health instruction to the family, such a call at the expense of the insurance company or the employer is not in itself justified.

REFERRAL FOR CARE

Perhaps the most effective way to secure prompt referral and elimination of non-nursing calls is to have the employee responsible either for requesting the service directly or asking the firm to do it for

him. In such a plan, the employee is told of this privilege at the time he becomes eligible and is reminded of it at intervals through leaflets, posters, house organs and talks. The next and perhaps the most important part of this plan is to have a representative of the firm remind the employee or his family of this service at the time when the firm is notified of his absence for illness, when he is securing a leave of absence for medical or surgical treatment or when he is being sent home from the dispensary. The representative of the firm can offer to refer the case to the nursing organization if the nurse has not been called by the family. In this way, either the employee or the representative of the firm refers the case, but the decision to have the service remains with the employee. Because most of the cases in the past have been referred by the employer, today's policy of making the employee responsible for requesting service requires constant emphasis by the nurse until the plan is well established.

To know how many and what types of cases are being referred by each firm, many nursing agencies are keeping annual record sheets on which they record the case and visit experience by firm each month. If there is a very interesting case, the name and case number are noted. In this way, the agency can know at once how much and how well firms are using the service. This information is also helpful in deciding which firms need a visit by the nurse representative.

In order to insure the very best use of the home nursing service, a few nursing agencies have included in their in-service educational programs a series of conferences on service to the "breadwinners" of their families. They review their family folders to determine how well the health and nursing needs of these members of their families are being met. Such conferences have resulted in study of scientific

facts about the prevention of minor illnesses such as foot ailments, dysmenorrhea and mild hypertension, preparation of a few new standing orders regarding these types of situations, institution of an invariable rule to pull and review all previous records of service to this family before visiting, stimulation of more interest in recording the patient's work and his attitude toward it and more interest in his whole 24-hour schedule, including food, rest, sleep, play and family life.

REPORTING FIRST EMPLOYEE VISIT

The report which the nurse sends to the employer following her first visit to a disabled employee can be used as a tool to bring about an improvement in the use of the service. For instance, on a too-late-reported case the nurse might state, under *Remarks*, "Patient convalescent; needed nursing service earlier, does not need it now" or "Patient returned home from hospital one week ago; could have used nursing service this past week." When the case is referred in time, the nurse might state, "Because patient was referred early, nurse will be able to give needed care."

VISITS TO FIRMS

There are two distinct and important types of visits to firms—the introductory or explanatory visit made at the time the nursing service first becomes available to the firm, and any follow-up visit made subsequently. The purpose, preparation for, and content of these two types of visits are usually entirely different and should not be confused.

EXPLANATORY VISIT

The purposes of the explanatory visit are to (1) become acquainted with the personnel and set-up of the firm (2) explain further what the service is (3) assist in establishing plans for using the

PUBLIC HEALTH NURSING

service and introducing these plans to the employee (4) outline the nursing area and (5) secure for the nursing organization this firm's plan for using the service.

Preparations for an explanatory visit vary, of course, but may proceed along these lines. First the nurse tries to learn something about the firm—its size, what it manufactures, whether the administrative personnel is active in civic affairs, and other facts. Then she reviews materials in the Group nursing folder. Many nursing organizations keep such a service folder containing all the general information and record forms for this type of service, nursing leaflets and posters and possibly some new or pertinent health education material. Before visiting a firm the nurse reviews these materials and selects those to which she will want to refer. In this way she can adjust the interview to the situation.

With the help of this folder and her previous experience the nurse now outlines the content of her visit. Next she secures an appointment with a responsible member of the management staff, a person designated by her organization or the insurance carrier. She tells him who she is and why she wants to see him. She asks him if he can arrange to include in the conference the person or persons who will be responsible for carrying through any plans. If there is a medical department, she asks to have the nurse included.

Upon arrival at the firm's office the nurse will probably spend the first few minutes introducing herself and becoming acquainted with the firm's representative and with firm organization and policies. Just as in a home visit, it is important for her to know the employment practices and the health program already in force. Before going into the next phase of her visit, if the person directly responsible for carrying through the plans is not present, she asks again that he or she be invited

to join the group. Then the nurse goes on to explain what the nursing service is and how her organization provides it. If the firm is Group insured, she reminds the employer that since only employees with Group insurance are eligible at the expense of the insurance carrier, the firm should give the serial number when the employee is referred and should tell the employee who refers himself to have the certificate number available. Next, she assists in formulating plans for using the service. This plan should include the procedures for securing referral of the employee already outlined. She explains how the nurse's report which is sent to the firm following her first visit to the disabled employee should be received and used. If the employer feels that having the nursing representative meet the executive staff or the employees for a brief but direct explanation would be helpful, the invitation should be accepted. Likewise an invitation to go through the plant should be accepted as a real opportunity to learn something about her patients. This may be shared with other nurses in her organization by a written brief report prepared for each district office. A special conference with the nurse at nursing headquarters may help to develop a coordination of nursing care for employees at work and at home that may add a great deal to its effectiveness.

FOLLOW-UP VISIT

As in home visiting, a second visit fairly soon after the first visit is often very worthwhile. It clinches, clears misunderstanding and cements working relationships. Follow-ups are made according to need and their frequency depends upon the number of employees, the use made of the service, types of cases referred, and the turnover of firm personnel, especially those responsible for referring cases. Except in unusual circumstances, or when

HOME SERVICE FOR INDUSTRIAL WORKER

the service is new, visits are not indicated more frequently than once a year. Where the number of insured employees is less than 100, visits may be even less frequent—perhaps every two to four years. If few visits, it may be helpful to mail an annual summary of the service to the firm with suggestions and an invitation for suggestions to improve it. If the service has not been used, the letter should remind the firm of the privilege. Where the number of insured employees is less than 50, visits usually should not be made unless a question or problem arises.

The purposes of the follow-up visit are to (1) review the nursing service experience and present plans for using the service (2) if indicated, enlarge or modify present plans for using the service (3) discuss specific cases (4) become acquainted with new personnel (5) review the nursing area (6) review the content and use of the report which the nurse sends to the employer following her first visit to the employee (7) discuss changes in the policy, the program, or the nursing area of the nursing organization.

In requesting an appointment, the nurse explains the purpose of her visit so that the representatives of the firm may also be prepared. She asks specifically to see the representative who refers the cases and the one to whom the nurse's report is sent. If there is a plant nurse, she asks to have her included in the conference.

In preparing for the follow-up visit, the nurse usually reviews the report of the last previous visit to this firm to determine what plans had been decided on. She reviews the current nursing records of service to see what types of cases are being referred, by whom they are referred, if the addresses are correct, and other details. She also reviews the annual record of service to determine the amount of service which had been given and to secure the names of interesting cases. She

makes notes of especially good or poor types of cases. It is very effective to prepare a written statement on these matters which can be used during the conference, and left with the firm. In addition, printed materials as previously suggested may be used. With her plan of visit made and her written report and other materials in hand, the nurse now follows through in her interview the purposes outlined for a follow-up visit. If the persons upon whom a follow-up visit is made are not familiar with the nursing service, it may be necessary to include some of the information given in the explanatory visit. If the firm is Group insured, she reminds the employer that only employees with Group insurance are eligible for nursing service at the expense of the insurance carrier.

REPORTS OF VISITS

Following either type of visit, a report is prepared. If the firm is Group insured, the insurance carrier provides a report form which it wishes to have completed and submitted before payment for the visit is authorized. The type of information kept at the nursing office is determined by the organization. It should include such details of the plan as the method of referring cases and the name of the firm representative to whom the nurse's report should be sent, for it has been found extremely effective to send a letter to the firm after a visit. In this the nursing organization's understanding of the firm's plans for using the nursing service is given in detail and the firm is always encouraged to compare this with their understanding of the plan. This confirming letter serves a dual purpose, providing a written statement of the plan in case of a change of personnel and giving the nursing organization an identical copy of the information which the firm has on file.

PUBLIC HEALTH NURSING

REVIEWING VISIT REPORTS

Some nursing organizations which have supervisors visit firms, plan meetings at which explanatory and follow-up visits are reviewed in detail. Following such a discussion, a nursing organization had one supervisor make an explanatory visit to one plant and another make a follow-up visit to a plant of a different type and then report on their actual experiences. Discussion of these visits was very helpful and practical.

Because it recognizes the importance and value of well-planned visits to firms, the Metropolitan Life Insurance Company has prepared a mimeographed outline of the purpose, preparation, content, and follow-through on explanatory and

follow-up visits. This is available upon request.

Nursing organizations that meet the three-fold challenge of giving essential home nursing care, making intelligent use of the nurse's report and carefully planning visits to firms, will play an important part in bringing about mutual understanding between the employer and employee and the nursing organization. They will also have the satisfaction of knowing that they are meeting the essential home nursing needs of the industrial worker whose time and energy are so important. In these days, when every use of professional nursing service must be justified, this is not only an opportunity and challenge—it is an obligation.

SEMINAR ROOM WILL HONOR SERVICE

The East Harlem Nursing and Health Service of New York City is no more, but if present plans materialize memory of its outstanding role in public health nursing and of its leaders, Grace L. Anderson and Mabelle S. Welsh, will be perpetuated in a seminar room for nursing students at Teachers College, Columbia University. In this room it is planned to place some of the furnishings that were used in the old red brick headquarters at 454 East 122 Street; reports, bound periodicals and pamphlets from the EHN&HS collection; and books which have been donated by

both Miss Anderson and Miss Welsh from their personal libraries. Formal dedication of this room will take place about the time of publication of Miss Welsh's report. Lay people and public health nurses—especially all nurses who were privileged to enroll with the Service for field study and observation—are invited to join the group who are sending contributions to establish this room. Anyone who is interested may get in touch with Elin W. Johnson, local chairman of the Committee, 301 East 61 Street, Apartment 1C, New York, N. Y.



Workers like these Indians in the marketplace in Oroya, Peru now are able to go to a fully-equipped, modern hospital when sickness strikes

Inter-American Health Program Goes Forward

By ALBERT DREISBACH, M.D.

ALONG the Amazon go floating dispensaries, bringing doctors and drugs to new settlements of rubber workers hard to reach by land. . . .

Into backwater swamps of Haiti, in sight of new fiber plantations, march anti-malaria squads with drainage equipment and larvicide in an all-out war on the mosquito. . . .

From Guatemala to Paraguay rise new clinics and hospitals to fight tuberculosis, a principal cause of death in the Americas. . . .

In all these and a hundred more ways, a great inter-American health campaign goes forward today in 16 American republics, some of which are sites of bases for hemisphere defense and all of which produce strategic materials for the arsenals of the United Nations.

The program is being carried out cooperatively by agencies of the Latin-

American governments and the Institute of Inter-American Affairs, a subsidiary of the Office of Inter-American Affairs, headed by Nelson A. Rockefeller, in Washington. As its contribution to the inter-American "Battle for Health," the Institute has assigned scores of doctors, nurses, engineers and other technicians supplementing the contributions of the co-operating American Republics. By safeguarding workers, the health campaign helps assure the flow of rubber, fibers, metals, vegetable oils and other materials to the factories of North America. It also helps lift the living standards of the Americas for the long run.

CHIEF consultant in this hemispheric program is Dr. George C. Dunham, director of the Health and Sanitation Division of the Coordinator's Office. A modern version of the physician on horse-

PUBLIC HEALTH NURSING

back, he is an airplane doctor with 25,000,000 patients. During a ten-month period he managed to ride his circuit five times and covered 57,497 miles. His tall, brawny, tireless figure has become a familiar sight in Port-au-Prince, Quito, Lima, Asuncion, La Paz and Rio de Janeiro. He is known to hundreds of public health authorities in the Americas. He has dispatched parties into the vast Amazon Valley, up and down the length of the Andes, into cities and jungles, hot climates and cold. His men are resourceful technicians who know how to cope with snakes, fleas, sting rays, electric eels, carnivorous ants and—most important—with the anopheles mosquito.

On the wall of Dr. Dunham's office in the Commerce Building in Washington is a large map of Central and South America, speckled with varicolored pins. Blue means building projects: hospitals, dispensaries, clinics. Black means sanitary engineering: sewage plants, water supply, drainage ditches. Red stands for medical units for treatment of disease. Green indicates health education and the training of nurses. Brown shows dispensary launches along the Amazon and its tributaries. There are hundreds of these pins. They march down the map through Mexico, Haiti, Guatemala, Honduras, El Salvador, Nicaragua, Costa Rica and Panama. They go down South America's west coast through Venezuela, Colombia, Ecuador, Chile and Peru. They swing over eastward to Bolivia, Paraguay and Brazil. They cover the great ranges of the Andes. They sweep 2,200 miles across the Amazon Valley.

TO FURTHER the program various republics have set up a "Cooperative Inter-American Public Health Service." More than 600 separate projects, units of operation, surveys and other types of pub-

lic health activity have been started or scheduled. What are these projects?

They are hospitals and health centers in mountains and jungle. They are medical and nursing schools. They are market places and slaughter houses for clean handling of food. They are sewers and disposal plants and pure water systems in the cities. They are clinics and doctors and surgeons, storehouses of medical supplies, chemicals and disinfectants, drugs and millions of atebine tablets to combat malaria.

The blue print for the health program was laid down in January 1942 at the Rio de Janeiro meeting of the American Foreign Ministers where it was agreed to strengthen the Americas by strengthening their health and well-being. The program got under way two months later in Ecuador. Since then dozens of technicians have gone south on survey trips. Local health authorities have joined in mapping projects. Equipment, medicines and supplies have flowed southward, and the widely diverse projects have taken shape. Many have been completed. New ones are being mapped continuously. The program finds its largest scope in the 2,000,000 square miles of the Amazon basin. Here is the largest potential source of rubber and other tropical products available to the United Nations. Into this area has begun a large migration of workers.

BUT there are enemies waiting for these workers in the jungle. The dangerous adversaries are malaria, typhoid, dysentery, smallpox. And so, with this army of rubber-tappers, goes a "convoy" of doctors, nurses and sanitary engineers.

With the assistance of the Health and Sanitation Division, Brazil has set up in the Amazon one of the greatest programs of preventive medicine in history. Twenty-two hundred miles across the val-

INTER-AMERICAN HEALTH PROGRAM

ley, like trading posts in a far-flung jungle, a chain of health stations is being forged.

Gateway to this rubber empire is Belem, which lies 90 miles from the open Atlantic near the junction of the Para River and the mouth of the Amazon. Belem is the assembly point and jumping-off place for the trek of Brazilian workers westward. From the moment the rubber tapper begins the march to the rubber forests, his life and well-being are guarded as never before. Along the trails to Belem a dozen rest stations are being built to receive rubber workers moving overland. The camps contain bathing and laundry facilities, dispensaries and isolation wards. Here the worker receives shelter, food, water, clothing. He also receives a medical examination, inoculations against yellow fever and smallpox, and anti-malaria drugs, free of charge.

In Belem itself, more than 700 men have been at work building dikes and tide-gates, cleaning and straightening channels and small streams, draining low areas to eliminate breeding places for mosquitoes and prevent malaria. Belem also is the site of a laboratory for studying mosquito specimens in the war on malaria. Hundreds of mosquito fighters in the Amazon Basin send specimens to Belem in the search for malaria carriers.

FROM BELEM inland, for 2,200 miles, Brazil is engaged in the construction of 5 major hospitals and at least 50 dispensary infirmaries to cover towns of a thousand population or more. Of the dispensaries, 35 are to be on launches floating on a circuit along the Amazon and its tributaries. Some of these health stations are already in operation. They will extend eventually all the way to Guayaramerin, where the Mamore River

forms a boundary between Brazil and Bolivia, and to Iquitos and Tingo Maria, in the Amazon headwaters of Peru, on the eastern slopes of the Andes.

Secondary headquarters of the program have been established nearly 1,000 miles up the Amazon from Belem at Manaus, capital of Brazil's first rubber boom, where an opera house remains as a memento. Also included are projects for drainage, sewage, water supply, personnel training and the distribution of a million tablets monthly of atebine, free of charge. Atebrine distribution, stepped up by newspaper and radio campaigns, is producing results. In one area formerly 15 percent of the population were afflicted by malaria; now the incidence is down to only 2 or 3 percent. Employed on the program are 1,500 Brazilians, of whom 40 are doctors and 7 are engineers. They are being assisted by a field party of United States technicians headed by Dr. Kenneth C. Waddell, noted for his pioneering health work with the Ford rubber plantations in the Amazon Valley.

Similar health programs have been launched by other nations with territories in the Amazon Valley, including Colombia, Peru and Bolivia.

THE health work is far advanced in Ecuador, where 34 separate projects are in progress. Scores of Ecuadoran technicians and more than 1,200 workmen have been engaged in work which has become an outstanding example of inter-American cooperation. In Quito, the capital, the first nursing school completed under the hemisphere health program is in operation, a tribute to cooperation among almost a dozen Ecuadoran and United States agencies. In a modernized building on the grounds of the Eugenio Espejo Hospital, 30 girls in the powder blue uniform of the probationer have begun a

PUBLIC HEALTH NURSING

three-year course that will meet the rigid standards of the International Council of Nurses. The students receive free tuition, uniforms, textbooks, materials, meals and living quarters. In Quito and Guayaquil, Ecuador's principal port, hospitals and laboratories are taking shape, modern sewers are being installed and drainage programs undertaken. In addition to the nursing school, the program in Quito calls for a 100-bed hospital for infectious diseases, a 200-bed maternity hospital, a complete health center to house the country's National Health Service and its many clinics, laboratories for the municipal health department and a new market place. In Guayaquil the program calls for a tuberculosis hospital, one for infectious diseases and a large maternity hospital, the addition of men's and children's pavilions at other institutions, a new building for the medical school, and the addition of an auditorium and six laboratories to the Instituto de Higiene. In Chimborazo Province, a war of extermination is being waged against rats and guinea pigs, carriers of bubonic plague. At Salinas, site of a United States military and naval base, another sanitary campaign is under way.

IN BOLIVIA a central office and supply post has been set up at Cochabamba. The Bolivian program extends the Amazon basin work, with malaria control and pure water supplies the most pressing problems.

Paraguay's health program has seen construction begun on a large health center at Asuncion, the capital, to house the National Ministry of Health. This center will include clinics for treatment of disease. Sites for other health centers in Paraguay have been selected. Projects include sewage and water supply facilities, hospitals, training of nurses and tech-

nicians and a tuberculosis sanatorium at Asuncion.

The first health and sanitation projects in Haiti have been completed. This work includes canals and drainage of marshlands for malaria control in the Carrefour Lighthouse area of Port-au-Prince, the Haitian capital; similar sanitation work at Bizoton; construction of water and sewage facilities at Fort Lamentin. Nearly a score of projects have been started or planned for Port-au-Prince and other Haitian communities. These involve malaria work, construction of market places, improvement of water supply and other sanitation facilities. The market places serve as centers for dissemination of health information. At Cap-Haitien a malaria control project is under way to protect workers on a 5,000-acre project for growing sisal, a strategic material.

In Peru a program has been launched to bring hospitals to its citizens, wherever they are. For example, San Martin, capital of a province, is almost unreachable, except by plane. It needs a hospital. So materials were flown in by plane to build the hospital. Tingo Maria, 520 miles from Lima in the Andes, is the center of a new agricultural colony, where crops thrive and disease organisms as well. So in Tingo Maria has risen a new hospital, with water and sewage systems. Chimbote, north of Lima, is a seaport and center of a coal and iron area. Through it comes the Pan-American highway. Plans for Chimbote include a hospital and health center, malaria control and sewage disposal. The Peruvian program also includes dispensary launches for Peru's Amazon area and health center in Lima, the capital.

IN CENTRAL AMERICA, from Guatemala to Costa Rica, the Institute of Inter-American Affairs is cooperating in more

INTER-AMERICAN HEALTH PROGRAM

than 75 health and sanitation projects. They include malaria control, health centers, sewage and water facilities.

Running through the fabric of this over-all health program are a number of subsidiary campaigns against tuberculosis, leprosy, yaws and typhus. Seven countries have launched projects to lift their nursing professions to the highest modern standards. The projects call for reorganization of existing nurses' schools, establishment of new ones for advanced and brush-up courses for nurses. Assisting in the work is the United States Public Health Service and the hemisphere-wide Pan-American Sanitary Bureau. Both agencies supply teacher-nurses, buildings, funds and texts, and lay out courses of instruction.

So goes forward the most imposing inter-American health program yet undertaken.

Speaking of the inter-American "Battle

for Health," Dr. Dunham says: "These projects, in keeping with the Rio development program, have been planned for immediate wartime needs in connection with hemisphere defense and development of rubber, fibers and other tropical industries.

"But, when the war is over, the hospitals, nursing schools, sewage, water and other sanitation facilities will remain to become enduring contributions to the health of our neighboring republics.

"The health and sanitation program should represent, in postwar retrospect, one of the notable achievements of friendship and unity of action among the Americas in these crucial years."

The two pictures showing women at work are by Charles Perry Weimer, noted lecturer and producer of "The Cavalcade of South America." The third picture is from the Office of the Coordinator of Inter-American Affairs.



Washing clothes in the jungles of Colombia is thorough but very hard on buttons

India's Public Health

INDIA in centuries past was periodically ravaged by famine, war and pestilence. Today internal wars and famine have been banished and pestilence reduced, making possible an annual population increase of three to four millions, but infant and maternal mortality rates are high and the state of public health low.

Preventable epidemic diseases such as cholera, the dysenteries, malaria and smallpox reap more than 1,810,000 deaths each year. General death and infant mortality rates are approximately twice and three times those for England and Wales or the United States; definitely higher than for Ceylon and markedly higher than for Java and Japan. They also compare unfavorably with statistics from other Far Eastern countries where population densities are higher and economic levels low.

Many factors contribute to the poor state of health in India. Foremost among them is the low economic level of the people, most of whom have a per capita purchasing power of $2\frac{1}{2}$ annas a day, which represents only $9\frac{1}{2}$ cents in our currency. Illiteracy and low educational standards also play their part. Social welfare organizations and legislation are pretty much undeveloped and, wherever they exist, have little effect upon India's 420 millions. There are no public health nurses in the country and an extreme scarcity of other nurses—only 7,000 as compared with 42,000 doctors. In addition there are 500 "health visitors," who are enlisted from a very restricted class of women because part of their activity is midwifery.

All of these reasons are in part responsible for India's poor public health, but none is as fundamental or important as India's climate and the characteristics and outlook of the people whose system of life and religion is difficult to reconcile with public health as Western nations know it. "Divine medicine," little changed in 1800 years, is still practiced in vast areas of India. Under this fatalistic system disease and death are punishments for sin and therefore not to be resisted. "Practitioners" carry out centuries-old techniques which often hasten death and aggravate disease. Women in childbirth are frequently relegated to the darkest, dingiest room in the house if it happens to have more than one room, and forced to lie on a dirt floor with practically no covers. Untrained native midwives or *dhais* subject the mother and unborn baby to practices which are likely to cause sepsis and other complications.

There is, however, a brighter side to the picture of public health in India which augurs well for the future. Medical research is heavily subsidized. Numerous research stations and institutes have world-wide reputations. Both Indian and British research workers—Sir Ronald Ross to name only one—have made outstanding contributions to knowledge about the epidemic and tropical diseases such as malaria, kala-azar, plague and cholera. But here again there is some disillusionment, for Dr. M. C. Balfour, regional director in the Far East International Health Division, Rockefeller Foundation, questions "if research in India has not far outstripped the application of

PUBLIC HEALTH IN INDIA

existing knowledge." Too often findings have defined the problem and found the most effective and economical methods of disease control but have not carried out that control in field services.

There is encouragement in the multiplicity of private associations, societies and funds, many of which engage in public health activities, health teaching and medical assistance. As such organizations have represented a stage in the development of public health consciousness in other countries, they should lead ultimately to government administration of these activities in India. They serve the useful purpose of stimulation and demonstration. A special bureau of the Indian Red Cross, which is in reality a form of government organization in India, has assumed or been assigned most of the maternity and child welfare work. In close cooperation with public health departments, it has trained midwives in modern hygiene methods; maintained schools for health visitors; made grants for experimental schools; prepared and issued propaganda leaflets, pamphlets, posters and films.

There are about 6,700 regular hospitals and dispensaries in British India, nine tenths of them controlled by the provincial governments, local bodies and the railways. In one year they take care of 1,000,000 indoor and 70,000,000 outdoor patients, a tremendous feat considering local conditions. Eight hundred maternal and infant welfare centers are maintained. The government is encouraging the people to form cooperative "anti-disease" societies to combat the mosquito and adopt preventive measures and so replace a philosophy of self-help for that of fatalism. The Rockefeller Foundation has assisted several states and provinces as well as Ceylon in the establishment of health units, whose activities are limited to preventive or public health service. These units have proved useful as demonstra-

tions of rural hygiene and have helped train health personnel, but according to Dr. Balfour, the staffs "have not appeared to be sufficiently qualified for such demonstrations, and health visitors are unfortunately not public health nurses." Supervision has been limited, and the annual per capita cost is proving more expensive than the local authorities could or would afford when outside aid is withdrawn. Therefore, local health service will probably be reevaluated.

All of these activities prove that some consciousness of public health is dawning in India, but the statistical record is still so poor and public health problems so gigantic that Dr. Balfour suggests that in order not to become disheartened a basic public health philosophy, applicable to India as well as other countries, is imperative. Cynics ask if, in view of the large birth rate and limited food supply, it is desirable and in accord with natural law to save lives and prevent illness in India. Dr. Balfour points out that a satisfactory health philosophy for India is not qualitatively different from the rest of the world. We must start with the promise that every individual, regardless of race, sex or religion has a certain birth-right to good health, freedom and the pursuit of happiness or contentment. To the purely realistic Dr. Balfour points out that in all countries the birth rate declines when the death rate is lowered, and that such a sequence must inevitably follow public health efforts in India.

In the last analysis, the effectiveness of public health and medical services in any country depends basically on the quantity and quality of its personnel, and the quality and amount of medical education in India at present need development. Nursing, which, to quote Dr. Balfour, is "the backbone of effective medical service and public health practice," is in a more backward stage than the other medical classes.

PUBLIC HEALTH NURSING

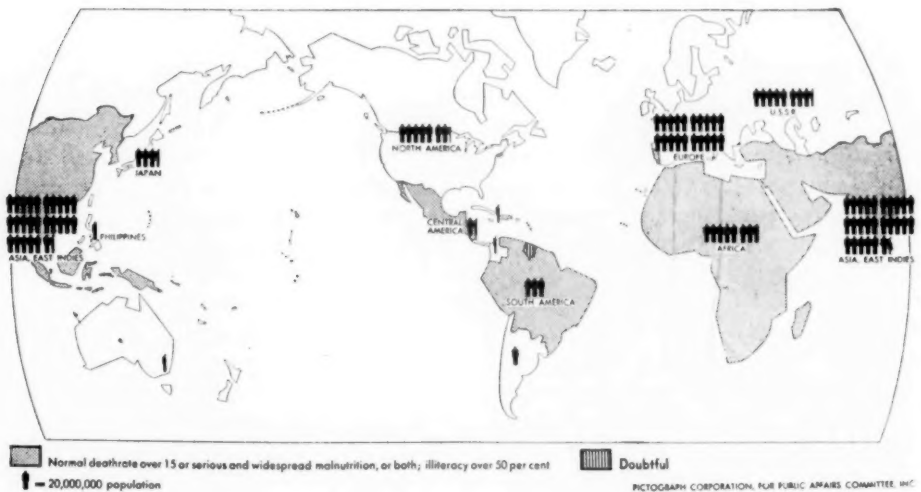
He considers this backwardness due to the obstacles of language, custom and social circumstances which have kept women of the more desirable classes from taking up nursing. The need for leadership in nursing is urgent and this leadership must come from Indian as well as European women. According to the Trained Nurses' Association of India, however, the old prejudices against women working are not the fundamental reason why India has so few nurses. Rather, it is because the government has not granted sufficient funds for training nurses, nor provided adequate accommodations for them even when funds are granted. Often new hospitals are built with extravagant equipment but with insufficient housing for a nursing staff. Even in comparatively well-staffed hospitals there is not enough supervision. If these conditions are improved, the Nurses' Association claims

that prejudice would readily crumble and there would be long waiting lists of suitable candidates for the profession.

The future of public health in India is problematical, but it holds great promise. A Central Advisory Board of Health has made an auspicious beginning and should play an increasingly important role in planning for health and medical services. But cooperative planning by individuals, groups and government is still seriously needed in the field of public health—especially in coordinating public health with the other social services. —E.W.

From three articles: "Some Impressions on Public Health in India" by M. C. Balfour, M.D. in *The Nursing Journal of India*, April 1943; "India's Medical Evolution" by A. P. Luscombe Whyte, released by the Agent General for India, Washington, D.C.; and "Maternity and Child Welfare in India" by E. M. Caldicott, Missionary Sister, in *The Australasian Nurses' Journal*, March 15, 1943.

WORLD MAP OF WANT



—From "Freedom from Want: A World Goal" by Elizabeth E. Hoyt, Public Affairs Committee, Inc., New York, 1943.

Freedom from Want

By GERTRUDE ZURRER, R.N.

THE public health nurse will want to take time to consider carefully the proposals for social security and compulsory health insurance in the United States, England and Canada as outlined in the much-discussed reports of the National Resources Planning Board¹ and Sir William Beveridge², and in the Canadian Health Act.³

Whether or not the nurse is personally in sympathy with compulsory insurance in general, or health and medical insurance in particular, she is bound to take an active interest in these reports. They are so clearly an expression of present social thinking and, if enacted, are going to affect so many people that she must decide for herself what part she will play in aiding their development. Nurses must accept this responsibility because no other professional group in the field of human welfare has a greater stock of experience in observing human needs and the workings of want. Since all compulsory social insurance schemes are essentially preventive and deal with general needs of large groups of people, the public health nurse whose work is likewise preventive and among large groups of the population must have a special understanding of the role of social insurance. She holds a unique position also in that she can observe individuals and family groups over long periods, during both good and hard times. Every true public health nurse comes to the point where, in real humility, she marvels at the resourcefulness, resiliency and adaptability of people. This

insight must be used toward bringing about legislation which will foster incentive.

For the nurse's purpose, these reports and other current social security and compulsory health insurance plans (none of which is yet a law) should be studied from these three angles:

1. What are the social principles underlying these proposals and how do they differ from earlier attitudes?
2. What are the specific provisions?
3. How would such legislation affect the nurse individually and professionally, and how would it affect nursing in general?

Only the first question will be considered here. The proposals differ widely in scope, but are impressively alike in many of their social implications. It seems more useful at this time to have a clear idea of present social thinking underlying these plans than to know their detailed provisions, but a very rough and brief outline is necessary.

CANADIAN HEALTH PLAN

The health insurance plan for Canada is a proposal for a broadly conceived program of health including medical, dental, pharmaceutical, hospital and nursing benefits for all people through compulsory insurance. The cost is to be carried jointly by the insured, employer and State (both the Provinces and National Government). The plan is complete and worked out in some detail—even to a place for subsidiary workers in nursing. It furnishes a good example by which the

comprehensive health services mentioned but not outlined in the NRPB and Beveridge reports can be visualized. The organization and division of responsibility are particularly interesting, because the relationship of Province to National Government in Canada is not unlike that of State to Federal Government in the United States.

BEVERIDGE PLAN

The Beveridge Report offers a plan for social security whose main feature is "a scheme of social insurance against interruption and destruction of earning power. . . ." Within this frame it considers children's allowances, unemployment, disability, old age and maternity benefits and a comprehensive health program (always including complete rehabilitation and nursing services). The plan is concrete, thoroughly thought-out and worked-through even to cost estimates and provisional cost comparisons. The outstanding features are coverage for the entire population, benefits on a true subsistence level and children's allowances to provide for families at all times. This report reveals both vision and immense practical understanding. It approaches the problems with such honesty and directness that to read any part of it is nothing less than inspiring.

NRPB REPORT

The NRPB Report for the United States is almost unlimited in scope and therefore less concrete. It covers large groups of people for unemployment, disability and old age benefits. It also includes a comprehensive health service for which no details have been worked out. In some ways the American Plan enters into the wider problems involved in the Atlantic Charter promise of "freedom from want," and into fields merely implied by Beveridge. For example, it

states in paragraph 8 and 456 that "organization of social insurance should be treated as one part only of a comprehensive policy of social progress."

UNDERLYING SOCIAL PRINCIPLES

In considering the social principles underlying all these reports, the first fact to bear in mind is that their recommendations grew out of existing social legislation and welfare provisions. Each recommendation embodies past experience and a certain amount of public preference. Obviously, for Great Britain, whose people have had experience with compulsory social insurance since 1908, the present recommendations can be much more positive and will represent more certainly the people's wishes than any plans which can be made for the United States where experience with national compulsory social insurance has been limited to a few years. This is one more reason for pooling what experience there is in this country, and public health nursing must bring out its store.

Each report is necessarily built within the framework of the respective government. This must also be kept in mind, because in Britain social security provisions, if adopted at all, will apply equally or at least equitably in all parts of the country. In the United States, where each state has certain sovereign rights, to judge social legislation merely by federal provision is to count chickens before they are hatched. The final application of such provisions depends upon each state's willingness to participate and its ability to pay. In some degree this applies also to the relation between the Canadian Provinces and their National Government. That each state in the United States has the last say in welfare legislation is nevertheless an advantage. As the NRPB Report points out, there is such a divergence in local needs as to

standards of living or available medical care that any national plan for social security, to be effective, must leave room for local adjustments. Such adjustments are best determined by the citizens of each state.

THREE PLANS COMPARED

It is significant that in spite of differing backgrounds and variety of scope, all three plans show the following trends:

1. Broader coverage, which means including more and more people in various social security schemes.
2. More adequate coverage, which means benefits on higher, more truly subsistence levels, insurance for ever more circumstances, and more comprehensive services.
3. Acceptance of the social insurance principle, which means compulsory contributory insurance for the mass of the people with some combination of cost distribution among insured, employer and State.
4. Abolition of means test except under public assistance.
5. Reorganization and coordination of public assistance with the social security program.

BROADER COVERAGE

The trend to bring more and more people under compulsory insurance is no doubt a sign that existing schemes have proved inadequate in that they have left large groups without protection. This is certainly true of the existing American social security which fails to include nurses who are employed by non-profit organizations. The new proposal remedies this, however. In Britain and probably in Canada, this trend to include more people may also be due to a growing realization of mutual dependence. This is expressed by Sir William Beveridge in a slightly different connection in paragraph 26 of his report, " 'Social insurance' . . . implies both that it is compulsory and that men stand together with their fellows." At any rate it is clear that existing compulsory insurance has

proved successful and popular. Otherwise, why should people want more?

MORE ADEQUATE COVERAGE

This is also found to be true in considering more adequate coverage. The method of coverage does not seem to be in question—only the adequacy. The demand for more services—such as maternity benefits, higher benefits on actual subsistence levels, and ever more comprehensive health protection—shows the general move away from temporary remedies through public assistance toward permanent protection from want through compulsory insurance. It shows a conviction that want is preventable, and this leads to the general attitude that a decent standard of living is due all members of society. Taking this for granted, all the reports develop their plans on the basis of need, not regardless of cost but with cost as a secondary consideration.

COST DISTRIBUTION

A distribution of cost among insured, employer and State is suggested in all plans. Beveridge warns that the burden can be borne only if distributed wisely.

ABOLITION OF MEANS TEST

The development of universal social insurance will deliver large masses of people from the indignities of means tests, for all three schemes emphasize there shall be no test of need. This is a logical outcome. If people pay for insurance, they have a right to certain returns. Under the new proposals, once the insured has complied with the contributory regulations, he is entitled to benefit regardless of other income or savings. Thus, in a rather remarkable way, people will have emancipated themselves from the strange dilemma of always being just not quite poor enough.

This only holds for the large majority

PUBLIC HEALTH NURSING

of the people, however. Both the NRPB and Beveridge Reports agree on and point to the fact that no social insurance scheme can be devised which covers all human needs under all circumstances. Recognizing that there will continue to be a need for some public assistance under a means test, it is suggested that public assistance be reorganized and coordinated with the social security program. Actually, insurance plans in both the United States and England depend heavily on public assistance during the transition period until universal insurance is established. It can reasonably be expected that once the insurance schemes are in full swing, public assistance will function as in theory it was always meant to do—as a relief agency for emergency and temporary needs.

It must not be deduced from the reports nor from this discussion that social insurance is a panacea or even an end in itself. As Sir William says in paragraph 440 of his report, "Income security which is all that can be given by social insurance is so inadequate a provision for human happiness that to put it forward by itself as a sole or principal measure of reconstruction hardly seems worth doing." He also says—and both the American and Canadian reports agree—that

such insurance is designed to "establish a national minimum above which prosperity can grow with [physical] want abolished."

This raises the question, "What is want?" At times, the difference between want and plenty is only a piece of bread. But in present terms, basic human needs are infinitely more complex. They include all kinds of minimum requirements that will insure the growth of human well-being. To the public health nurse, the most important message in all three reports is that a comprehensive health service, including nursing, has now been included in these minimum requirements for all people. Such a proposal as the Canadian Health Act could never have been prepared without the general conviction that a comprehensive health service is essential to national and individual well-being. The same conviction is expressed in other reports.

Whatever part public health nursing may have played in the formation of this conviction, it is obvious that the part it will play in the future furthering of human welfare will be even greater. If the nurse has wondered why she should interest herself in proposals for social security, this should be her answer.

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Patterns of Combination Agencies---1942

By HORTENSE HILBERT, R.N.

THE NECESSITY for efficient administration of community nursing and for strict economies in nursing personnel has been greatly emphasized by the war. As a result, there has been renewed interest in the coordination and combination of community public health nursing resources so that at least essential health needs may be met despite reductions in medical and nursing personnel available to the civilian population. The numerous requests that come to the National Organization for Public Health Nursing for information and advice about merging or combining public health nursing services show particular concern about methods of joint financing and government.

In order to have some recent information on this subject, the NOPHN sent a letter of inquiry in December 1942 to a sample of 40 agencies which in the NOPHN 1941 Census of Public Health Nursing Agencies designated themselves "combination agencies." Of the 24 agencies which replied by March 1943, 3 are in the southern, 4 in the western, 7 in the central, and 10 in the northeast and middle Atlantic areas of the United States. Sixteen states are represented. The agencies vary in size from 3 employing 1 nurse to 1 employing 57 nurses.

YEAR OF COMBINATION

Of the 24 agencies reporting, 20 gave information as to the year in which the combination took place.

Number of Agencies	Year of Combination
1	Before 1918
12	1918-1923
1	1924-1938
6	1939-1942

Evidently, combining community public health nursing services was most popular during the period 1918 to 1923. This was followed by a 15-year lull, and then by a renewed interest between 1939 and 1942.

KINDS OF AGENCIES IN THE COMBINATIONS

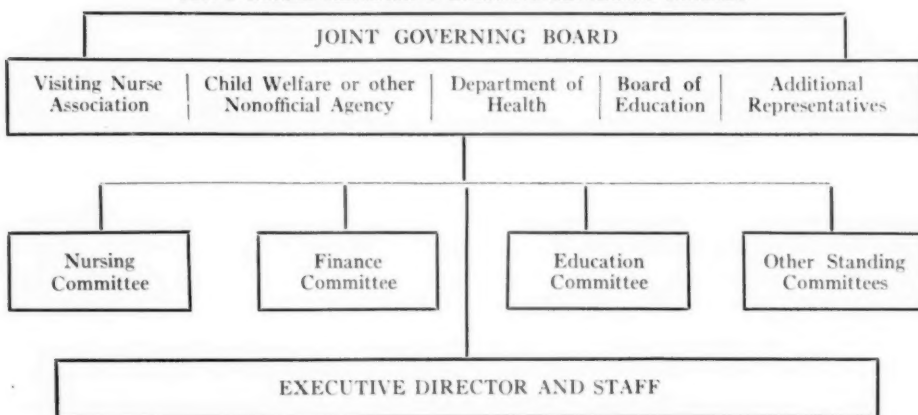
In 4 communities the arrangement seems to have been that of purchase of service by 1 or more official agencies from a nonofficial public health nursing association rather than an actual combination of already existing agencies. In 1 of these communities, both the board of health and board of public welfare purchased such service; in another, the board of education; and in the other 2, the board of health.

Both official and nonofficial agencies were represented in all of the 20 remaining combinations reporting. In 12 communities, a nonofficial public health nursing agency and the nursing service of a city or county health department united to form the combination service. Of the nonofficial agencies, 10 were public health nursing associations, and 2 were welfare or "charities" organizations.

In 3 combinations, 3 agencies were involved—a public health nursing association and a department or board of health in every case, plus another voluntary or

PUBLIC HEALTH NURSING

CHART I
JOINT BOARD REPLACING EXISTING SEPARATE BOARDS



official agency. The latter included child health stations of a nonofficial organization, an American Legion nursing service and a board of education.

In 5 communities, more than 3 agencies made up the combination—4 agencies in 2 communities, and 5 or more in the other 3. The public health nursing association and the city health department were always part of these combinations. The additional official agencies represented in these more complex combinations were county and state health departments, boards of education, the "city nurse" and township commissioners. The additional nonofficial agencies were health centers, milk depots, tuberculosis associations, Red Cross nursing and infantile paralysis services.

The 20 combinations having some joint administrative relationship other than by purchase of nursing service from a voluntary agency were characterized by one or more of the following relationships: (1) joint governing boards (2) joint funds (3) joint staff and (4) cooperative administration, activities, and facilities, such as joint staff conferences and housing arrangements.

GOVERNING BOARDS

NEW JOINT BOARDS

In 7 of the 20 combination agencies that reported more than purchase of service, new joint boards were formed from old boards. In 3 of these, the individual old boards were also retained; in 2, the old boards were not retained; and the other 2 failed to give the status of the old board. Chart I illustrates this type of organization.

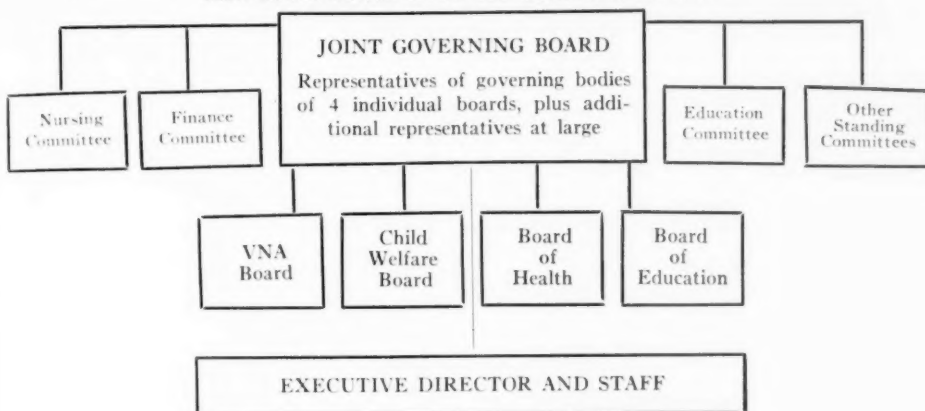
It is of interest that 2 of the 7 combination agencies here under discussion retained the name of the largest agency, which was the visiting nurse association, and that the other 5 took new names. In 1 combination, comprising a "charities association" and a health and nursing center, both nursing and health lost their identity in the new name. It is also interesting that funds for nursing services were pooled in 3 of these 7 combination agencies having joint boards, but were not pooled in the other 4.

NEW AND OLD BOARDS

Three of the 20 combination agencies organized a new joint or coordinated board when the combination became ef-

COMBINATION AGENCIES—1942

CHART II
NEW JOINT BOARD WITH OLD BOARDS RETAINED



fective, but each individual agency entering the combination also retained its own board. These coordinated or joint boards were made up of representatives of the governing bodies of each of the individual agencies. Chart II serves as an illustration of this kind of organization.

In 1 of these 3 communities, the joint board was organized through the community health council; in another, it took the form of a joint nursing committee; and in the third, it was known as the board of trustees. In none of these agencies were the funds for nursing service deposited in a common pool.

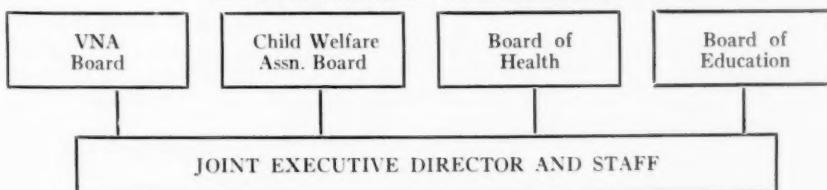
OLD BOARDS

In 11 of the 20 combination agencies, old boards were retained by the individual agencies and no new joint boards were

formed. In 1 of these where the public health nursing association joined with the health department, the old board of the nursing association was retained as the nursing advisory committee. Chart III illustrates this plan of government.

All but 1 of these 11 combination agencies represent the joining of the nursing service of a department of health with that of a voluntary organization. In the community which is the exception, the nursing services of city, county and state departments of health joined with a visiting nurse association and a tuberculosis association. In 10 combinations, the title of the voluntary public health nursing agency was adopted; in 1 the title of the combination included the names of both agencies. None of the combinations in

CHART III
OLD BOARD RETAINED BY EACH AGENCY



PUBLIC HEALTH NURSING

TABLE I
SOURCES OF INCOME IN THREE COMBINATION AGENCIES THAT POOLED THEIR FUNDS

	Agency 1		Agency 2		Agency 3	
	Amount ¹	Percent	Amount ²	Percent	Amount ²	Percent
Total income	\$56,596	100.0	\$127,713	100.0	\$1,987	100.0
Tax funds	45,760	80.9	34,349	26.9	1,587	79.9
Endowments .....	.....	.....	15,231	11.9	.....	.....
Contributions	10,081	17.8	60,294	47.3	400	20.1
Earnings .....	.....	.....	17,666	13.8	.....	.....
Other	755	1.3	173	0.1	.....	.....

¹For the year 1942.

²For the year 1941.

which the individual agency retained its old board deposited its funds in a common pool.

POOLING OF FUNDS

As already mentioned in connection with governing boards, actual pooling of funds for nursing services was reported by only 3 of the 20 combination agencies. These 3 formed new boards at the time of the combination.

SOURCE OF INCOME

Table I shows the sources of income of the 3 combination agencies pooling all funds for nursing service. Agency 2 in this table had the largest income of any of the 24 agencies reporting, and agency 3 the smallest.

TAX FUNDS

All 24 agencies in this review received some tax funds, 9 of them receiving 50 percent or more. The median was 44 percent. According to the United States Public Health Service classification, which calls *official* those agencies receiving more funds from taxes than from any other source, 11 of the 24 agencies here included would be termed official agencies.

CAPITAL FUNDS AND ENDOWMENTS

Some capital funds and endowments were reported as sources of income by 13

of the 24 combination agencies, but in 8 of them the percentage of total income was small—less than 3 percent. In the other 5, the proportion reported was from 3 to 12 percent.

CONTRIBUTIONS

Every one of the 24 agencies reported some contributions, but 1 reported less than 1 percent. Among the other 23, the range was from 12 to 72 percent, the median being 41 percent.

EARNINGS

All but 2 agencies reported earnings. The proportion of these earnings to total income ran all the way from 1 to 44 percent. The median for earnings was 14 percent.

POOLING OF PERSONNEL

Excluding the 4 combinations representing purchase of nursing services, the remaining 20 reported some sharing of nursing personnel or administrative costs other than salaries—such as headquarters, maintenance, transportation and supplies. In 17 combinations, personnel was pooled. In 1, where the relationship is largely that of cooperation and integration of service rather than actual combination through joint government or joint funds, 3 nurses remained on the health department staff, and 2 additional nurses employed by the

COMBINATION AGENCIES—1942

health department were assigned to the visiting nurse association. Coordination was brought about by close cooperation between the administrators of the 2 agencies and joint staff conferences.

SUMMARY

Judging by the information received from these 24 combination public health nursing agencies, "combination" connotes varying degrees of merging and various types of administrative relationships. In 4 agencies of the sample, "combination" means that 1 or more agencies purchase service from a public health nursing association; in 3 others, that funds for nursing services are deposited in a common pool by 2 or more agencies and that there is a joint governing board; in 16 agencies, that still other kinds of joint financial participation are used. Four of these 16 have and 12 do not have joint boards. The 12 not having joint boards retain the separate old boards of the individual agencies. In 1 of the 24 agencies "combination" means integration of service and cooperative administration between a public health nursing association and a city health department with some interchange of personnel, rather than joint financing or government.

Where public health nursing service can be purchased from a public health nursing association by other agencies responsible for providing this service for a particular group of clients, duplications and other wastes in administration can be avoided and greater efficiency and higher quality of service achieved. Among those who buy such service are insurance companies; boards of public welfare, education or health; tuberculosis associations; and individuals who make direct payment for this service.

One large, well-coordinated agency can, as a rule, provide better leadership and

more favorable conditions of work including supervision and in-service education, than can a variety of small ones—especially if they are non-health agencies. It can also usually attract better qualified public health nursing personnel. That the governing board of the public health nursing association from which service is purchased should be widely representative of the community and include representation from the agencies that have a stake in the provision of public health nursing is self-evident.

When several agencies already involved in the administration of public health nursing decide to unite there are usually several stages before the combination or union is complete. "Combination agency" is apparently applied to varying stages preceding a complete merger as well as to the completed merger which implies common government and common funds. Some of the stages represented in the evolving from a variety of separate community agencies to a unified community nursing service are:

1. A joint executive director or administrator, but separate governing boards, funds and field staff.
2. A joint director and coordinating board, plus separate boards, funds and field staff.
3. A joint director and field staff, and joint board, but separate funds.
4. A joint director, field staff and board, and also joint funds.

In some communities, the "combination agency" includes all of the public health nursing service of the community; in others, only a part of such service. Of the 3 types of agency that most frequently administer public health nursing throughout the country—departments of health, boards of education and public health nursing associations—boards of education are least often part of a "combination agency."

In connection with this review of com-

PUBLIC HEALTH NURSING

bination agencies, it is pertinent to recall some recommendations made in the recently published report of the NOPHN survey of needs and resources for nursing care of the sick in their homes* which were common to the majority of the 16 communities surveyed:

Coordination or amalgamation of nursing services in a manner to bring about unification of effort, economy in the use of public health nursing personnel and facilities, and competent nursing leadership, supervision, and in-service education was urged.

The establishment of a community-wide public health nursing committee, with non-professional citizen representation as well as representation from organizations and agencies interested in public health nursing services is essential to their best development. The first and foremost functions of such a committee should be to study nursing needs, and to support and help develop the best type of organization for meeting them.

*Public Health Nursing Care of the Sick. National Organization for Public Health Nursing, New York, 1943.

Wherever a well organized public health agency, such as a department of health, already exists, the community-wide general public health nursing service, including care of the sick, should become part of such an agency. Where there is no such competent agency, the community-wide nursing service must probably be developed separately through a strong public health nursing committee which is truly representative of the community.

The community-wide nursing service, if it is to fulfill its real purpose, should provide all types of service on a pay, part-pay, and free basis.

If nursing service is provided under intelligent, capable community leadership and under competent direction, practicing physicians, insurance companies, welfare departments, child-caring agencies, and many other groups will for efficiency and economy purchase services from a common source rather than provide their own.

The conclusions and recommendations in this survey report, made under the auspices of the NOPHN Committee on Nursing Administration, have also been endorsed by the Committee on Administrative Practice of the American Public Health Association.

International Council of Nurses

(Continued from page 423)

help to those who are suffering from the havoc of war's devastation.

One is impressed with the similarity of the problems which come to the I.C.N. from every land with which there is contact. The most immediate and fundamental problem seems to be the recruitment of students for schools of nursing in order to meet the requirements of civilian and military hospitals. Associated with

recruitment, questions are closely interwoven regarding standards of education and the status of nursing. Although members are separated widely in every continent of the world, they are attempting to solve their problems in much the same way. This strengthens the desire of the Council to provide for them the opportunity to exchange ideas and experiences. Wherever health and medical programs are organized for service to the nations of the world, nursing should be ready to take its place.

The Industrial Nurse in Her Community

By EVA CATON, R.N.

IN THESE DAYS of stress and turmoil, the nurse in industry is as important as the nurse on the battlefields. She is concerned with the health of an essential body of our population. Its health problems are of tremendous importance not only to the conduct of the war but to public health in general. What more strategic opportunity has an industrial nurse of serving her community than working with these important groups? She is adept in meeting emergencies, conserves time and energy, and her experience has taught her to use available facilities to the greatest advantage possible.

Total health—our first line of defense—lies in the strength and vitality of our people. To keep our nation strong and its people physically fit, we must today make every provision to see that the health of the worker is properly maintained. Any consideration of industrial health must include attention to community health. What better channel for helping community health work than industrial medicine? No other phase of medicine is more intimately related to the socio-economic problems confronting the nation. To the segment of our people who need it most, industrial medicine can offer a service that will prevent disease, give medical and surgical care, train the handicapped, and rehabilitate the idle.

WORKERS are prone to consider the industrial nurse a counsellor for their individual and family problems.

To solve these problems in many instances necessitates the use of community agencies.

Overcrowded housing conditions in war boom towns bring many problems of sanitation and the threat of epidemics endangering the health of our workers. The industrial nurse's affiliation with her local department of health will aid in combatting these conditions. She can also influence a worker's attitude toward an intelligent facing of these problems.

Her personal contact with him enables her to disseminate information about personal and home hygiene. She can explain how infection is spread and what members of his family are most susceptible, the precautions necessary to prevent it, the importance of protecting himself. Knowing each worker, the industrial nurse can adapt instruction to his understanding and make it practical enough to be of use in specific situations.

Health education is not accomplished only by personal contact, but also through the use of literature and visual aids relating to diet, personal hygiene, communicable diseases, and similar subjects which can be carried home by the worker. Cooperation with the local doctors and correlation of the industrial nursing program with that of other agencies creates a mutual interest and understanding of related problems. Our government is doing its utmost to maintain the health of our people, and its published materials are a source of inspiration and facts, as well as a means of spreading the gospel of health.

PUBLIC HEALTH NURSING

WITH available manpower for industry ebbing like sand in an hour glass, womanpower is fast becoming an important factor in the war effort. The industrial nurse can help ease the stress and strain on women in industry by helping to ensure that local nurseries provide adequate day care programs for children. Her acquaintance with the school system enables her to urge the need to keep schools open for longer hours, to provide recreational services for children of war workers thereby relieving mothers of worry and enabling children to develop in a healthful environment.

With so large a group, it is certain that many women will become pregnant at some time during the period of their employment. In order to prevent sickness and disability of these mothers-to-be and possible deaths of infants before births, information about the importance of adequate prenatal care and where it can be obtained should be available to employees.

During the past year, casualties at home were many times the number of war casualties. Our country's safety depends on our safety, for accidents are no longer solely a matter of individual and family concern; instead they affect our nation's entire war effort. Eternal vigilance is the price of safety, not only on the job, but at home, on the streets and elsewhere. Make both employees and nurses safety conscious. One period of training won't do it; safety habits and alertness day in and day out must be developed.

Workers replaced by those unfit for military service, more women employees, increase in number of employees, many young people entering industry for the first time, working hours increased and manufacturing speeded up—all call for adjustments on the part of the worker. In his attempt to make these adjust-

ments, the worker frequently develops disturbances of a mental and emotional nature. By the industrial nurse's alertness, she is often able to see the approach of neuropsychiatric problems and prevent them by directing the worker to the proper source for help.

THE PROBLEMS mentioned thus far have concerned those on the home front, but what about our responsibility to the Red Cross that stands ready to meet wartime needs both at home and abroad? It has contributed much toward civilian defense by setting up standards for first aid. And who is better equipped to teach first aid than the industrial nurse? She can take the necessary steps to become an authorized Red Cross Home Nursing and First Aid Instructor, solicit volunteers, make appointments for Blood Banks. She can help promote interest and participation of the entire community in increasing the number of nurses for the armed forces, by developing active chapter committees on nurse recruitment on which lay members will work together with professional members to fill this Red Cross obligation. She can help recruit young girls to enter schools for nurses, get young nurses in training into the Student Nurse Reserve, persuade older graduates to come back to active nursing work, encourage them to take refresher courses and encourage classes for nurse's aides.

The capacity and eagerness of the industrial nurse to render emergency services beyond the scope of routine duty is no accident. It is the result of years of experience and initiative. Now devoted to winning the war, she knows there can be no victory on the battlefield without complete victory on the home front.

Presented at the meeting of the American Association of Industrial Nurses, New York City, May 1, 1943.

The Nurse's Part in Health Education

By MARGARET BLEE, R.N.

MEN HAVE made progress individually or collectively by learning to rely on themselves. The terms "education" and "learning" cannot be dichotomized since education has little value unless learning is attached to it. As educators have expressed it, "The goal of education is the production of individuals who intentionally and understandingly participate in the life of their generation."¹ The best teacher is he who teaches each to help himself.

There has been repeated recognition that the greatest deficiency in a program of health education lies in its method of distribution. "The rapid advancement of medical science," a phrase frequently met in literature, is meaningless unless its achievements are applied or brought into relation with social experience.

In the past the zeal to share scientific information by means of health education has been based largely on the tutorial system of instruction in homes. Teaching in groups was less frequently utilized.

Early programs emphasized health of children. It was expected, or rather naively hoped, that when children learned the beatitudes of health they would carry most of this knowledge home to their parents who would adopt it. Family patterns crystallized by generations of tradition were disregarded. Public education for children is designed for their own generation—not the preceding one.

Mass education is believed to be effective. Professional literature points to the

abundance not only of scientific knowledge but also of facilities and techniques now available to improve the health level. But this same literature loudly laments that all these achievements are ineffective unless the public at large understands them. The popular method of health education today of informing the public through newspaper publicity, printed matter, meetings, radio, exhibits and motion pictures, resembles propaganda more closely than it does education. Hogben significantly states, "All good education is propaganda. Good propaganda is not necessarily education."²

Health education has some maternal aspects. Many times it is characterized by the "luxury of doing good" in that it does things *for* people and *for* communities. Statistics frequently determine community health needs, and programs are planned to meet them. Too often a community has only slight appreciation of what the statistics represent and is not aware of its needs. Nor does it understand the program imposed upon it.

This misconception gives rise to the too prevalent idea that public health nursing service and health education are principally for the lower economic groups.

THE VARIOUS methods of health education have travelled the professional orbit and have reached the crossroads. Early efforts are history. The maternal era has passed. Public health's infant child Health Education has matured and

is ready to mingle and share with other community agencies and forces to further not only its own welfare but also the welfare of others.

If a child receives health instruction in school today, some way must be found whereby his parents receive concurrent instruction in similar subjects. Community adult classes correlated with school subjects sponsored by a health agency might be a solution.

Home visits by nurses to spread health information have been described in glamorous terms of effectiveness. Important as they have been in the past and still are, they do not reach the entire community. A health program is supposed to be for all the people, and not for any select group. One of the chief complaints of health departments is "insufficient personnel—not enough nurses." To reach the entire community budgets are expanded to employ more nurses. If present programs continue, the complaint will be chronic. An enlarged staff of nurses making an increased number of home visits and organizing more clinics and child welfare stations does not diminish the problem of reaching the whole community because this type of program is concerned only with the group in the lower economic brackets. The patient needs and receives service when he is in the hospital. It is not strange that this conditioning influence penetrates public health services. Home visits as a device to cover a wide territory are expensive. Also, limited transportation forces us to seek other means for distributing health information. Group instruction of adults correlated with other community agencies and clinics is one possibility.

Many of the present specialized duties of nurses would have to be restricted or sacrificed, for example, "interpreting the doctor's orders," a phrase and service fa-

miliar to many. Does a physician who has spent from eight to nine years preparing for his profession need a nurse with four to six years of preparation to interpret instructions to mothers who may not have finished grammar school? Even these women must wonder why it takes two people to give instructions.

Adult education, a community force, is crying for attention. Due to new discoveries in medicine and health practices the concepts of health change, and the interpretation of it changes with each generation. Studebaker has said, "There are approximately three times as many citizens in 'adult life' as in 'school life.' . . . Adult life is three times as long as school life."³ Yet public health literature gives the impression that health education is concerned with school children alone and not with the general public as well.

Too frequently public health nurses and health officers believe they hold priority on health education. Other professional groups do not always support this notion. Any concept of health is dependent upon the background and interest of those concerned. The physical educator, of course, has a prime interest in health. The church is concerned with the spiritual health of its members. The school believes that it has the responsibility for the health of the school child. Nurses and physicians point out that close contact of nurses in homes places them in a strategic position to act as health educators. The tenability of these claims is nebulous without the support of medical science. The attitudes of churchmen, school and physical educators may not be in accord with public health ideas, but they are community forces with which public health people may well reckon. When we learn to think of ourselves as only one and not the exclusive means of promoting health

education our efforts will be more effective.

A COMMUNITY belongs to the people. It is their responsibility to see that it is a sanitary one with a high level for its members. The function of health and nursing agencies cannot be adequately interpreted within the present framework of home visits, clinics, mothers' clubs and American Red Cross home nursing classes. There are two reasons for this—first, the number of homes reached is insufficient; second, the clinic clientele is usually composed of those who cannot afford the services of a physician.

The function of the public health nurse is to make public health public. To be effective in this role she must discard some of the old and outworn methods prescribed by tradition, such as repeated visits to homes of the poor. This program is a heritage of the benevolent service furnished by early health visitors. If she is to be a potent factor in the total health program and its most effective medium—group work—two major changes are involved: (1) a redirection of attitudes so that attention would be focused on groups and not individuals and (2) redirection of activities so that public health nurses would have time and opportunity to be *community* persons.

In rural areas group work takes the place of social gatherings. Group discussion offers checks and balances in that information so received is not quite so likely to be misconstrued. Groups are vital community sources which spread what they learn. Despite rapid and direct means of communication the "grape vine" is just as swift and potent as ever. Redirection of public health nursing activities can be achieved by curtailing home visits and using this time for group instruction in clinics. Volunteers could

perform many routine clinic tasks, thereby relieving the nurse of her set role as an assistant to the doctor. When citizens work closely with physicians, nurses and patients in the health agency, they gain a clearer understanding of the agency's program. The main purpose of attitudinal direction is to invite a wider participation of the community. Group work is more important at present than it has ever been before, as it contracts both time and travel.

Mass methods to inform the public have had a long and we hope successful run. They have created an awareness of the importance of health. By and large health workers have handed out free pamphlets, lured people to clinics, made home visits, given scattered classes to women as if the health of men did not count. Most of these activities have been by the rural free delivery. We have asked little and received no more from the people. If health education is as important to the public as we ourselves believe it to be, then it is worth some effort on the part of the public to secure it.

Organized groups and clubs are characteristic of American communities. In group work the possibilities for teaching preventive aspects of health are enormous. In many programs, with the exception of immunization promotion, little is taught about prevention—after all a function of public health. If a family has a communicable disease, the health department may placard the house, have a nurse visit and teach the mother how to care for the patient and protect other members of the family. In a broad sense this is not preventive work; it is care of the sick. Since there is no way of knowing which home will be invaded by a communicable disease it is impossible to instruct mothers individually in measures to be instituted immediately prior to the onset. Fre-

PUBLIC HEALTH NURSING

quently, an individual is desperately sick before a physician or nurse is called. A series of classes given to groups before the time when certain diseases are usually prevalent would at least fortify parents with some knowledge of how to recognize symptoms and what to do before the physician or nurse arrives.

It has long been believed that only people limited in education and finances are in dire need of health education. Probably their ready availability has fostered this idea. Such program emphasis opens an avenue for criticism that health information is for the less fortunate. In contrast to this idea, it has been assumed that college people exposed to the magic wand of education have been inoculated with health knowledge.

An attempt to meet middle economic group needs was made last spring at the University of North Carolina when a successful adult education course in nutrition, taught by a professor of biochemistry, was offered. The group was composed primarily of faculty wives. About 95 enrolled for the 34 scheduled lectures. The efforts of a public health nurse started the machinery and kept it well oiled throughout the course.

COORDINATED monthly meetings in which representatives of agencies report and discuss their work is a group method for informing the public and maintaining equal interests in a program. Agencies have much to gain by understanding the tools used to gain their objectives.

The pooling of community forces might be invaluable in raising health levels. The health of a community is so vital and so broad that to try to place sole responsibility for its care in one agency is asking the impossible. When the abili-

ties of all trained personnel in all agencies are used, the burden of this responsibility is shifted to the community where it rightfully belongs.

Literature has a host of panegyric phrases for nurses—"the blue-clad figure," "the arms of the hospital and physician reaching into the homes," "catalytic agent," "the messengers of health"—and repeated messages have been carried to Garcia. These terms may have served a purpose, but they are not precise descriptions for nurses who have the military rank of colonel, captain, or lieutenant, or for those defenders of the Philippines who have been decorated for service. We have outgrown the childish role of messengers. And we are not extenders of either hospital or physician. We are professional women in a competitive world, and if we expect to take our place in public health or among other professional groups, we cannot continue allowing ourselves to be called by romantic names.

The past work of public health nurses carried out on an individual basis has had an important place in public health nursing. It was a noble beginning. We had to learn about the homes of families. The only way to do this was to visit them. Now the technique of family health work is well known. The next step is to extend our margins to the community and its wealth of resources. Never before have we been called upon to make so many changes and to make them so rapidly. Perhaps the present emergency will force us into fields of wider service. Neither our abilities nor those of other community workers have ever been used to full capacity. If these capabilities are not exercised, they will atrophy. When we learn to give leadership without demanding slavish agreement we will invite community participation.

HEALTH EDUCATION

New horizons call for changes in attitudes in program planning and the co-ordination of activities. Scientific achievement is for the benefit of the race.

Let us add our abilities to those of other community workers and dedicate our knowledge to the common needs of mankind.

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²Hogben, Lancelot. *Dangerous Thoughts*. W.

W. Norton and Company, Inc., New York, 1940. p. 154.

³Studebaker, John W. *The American Way*. McGraw-Hill Book Company, Inc., New York, 1935. p. 31.

Comments on "The Nurse's Part in Health Education"

MISS BLEE's article, "The Nurse's Part in Health Education," challenges us to re-examine some of the guiding principles upon which public health nurses have based their activities in order to discover the extent to which they meet present needs.

She brings to our attention many significant facts relative to the nurse's role in health education which include: the important opportunities for group education which have been recognized as a legitimate and effective means of achieving the objectives of the public health nursing program of health education but which have not been developed as extensively as their value would justify; the need for developing a program of group instruction which is correlated and integrated with clinic activities; the development of parent groups to keep parents informed and aware of the newer developments and changes in scientific health knowledge and the content of the curriculum of health instruction in the schools.

A significant point emphasized is the complexity of community interests in health education and the numerous agencies which have legitimate interests in developing and participating in programs of health education. This necessitates recognition on the part of the public health nurse that she has no priority in the administration of the program of health education but rather that interdependence exists between community agencies. This necessitates more thoughtful, critical analysis of the problem in order to determine the scope, limitation and unique contribution which the nurse is able

to make because of her ability and preparation in nursing.

While there would be agreement that public health nursing organizations should utilize group instruction as a means of achieving their objectives in health education, many would question the suggestions made by Miss Blee in relation to the home visit. Thoughtful public health nurses agree that many useless home visits have been made in the past; that administrative policies relative to the frequency of home visits for specific types of services have tended to routinize the work of the public health nurse and have relieved her of the responsibility of determining the frequency of a home visit on the basis of individual need. This has resulted in a wasteful expenditure of professional nursing service which is costly from every standpoint. Many public health nurses would not agree that home visiting is diminishing in value, that it is an "old and outworn method prescribed by tradition." They would hesitate to subscribe to a program of group instruction which excluded or minimized the value of home visitation. These public health nurses would argue that concepts relative to the significance of the home visit have changed with other changes in the field of health; that a visit in the home offers a most unique opportunity to study and observe the environmental factors which influence the individual's growth and development, attitudes and interests and help to determine his specific and particular needs. On the basis of this information, constructive group work could be a logical outgrowth of and correlated with

PUBLIC HEALTH NURSING

the home visit, and the home visit continue to be one of the effective means of recruiting members for the group.

In the last analysis all learning is an individual and not a group process. Some individuals may be stimulated by group action and participation, and learning will be facilitated for them. There are others with whom the reverse is true. In other words, it is not one or the other method but rather the utilization of the method which is indicated on the basis of individual needs. If we accept the philosophy of individual differences it seems inconsistent to select any one method as the "most effective medium."

Miss Blee raises many debatable issues in her article. The limitations of this discussion permit merely an opportunity to indicate some of them. For example:

1. Present day practice in public health nursing limits the home visit to care of the poor and therefore is an outmoded method of health education.

2. Emphasis on the program of health education for the school child has little, if any, effect on parental attitudes, and behavior.

3. Rendering bedside care to a patient with a communicable disease is chiefly a curative nursing service.

4. Group work is more effective than the home visit as a medium through which to carry on a program of health education.

5. The present framework through which public health nurses interpret their function as health educators is limited to home visits, clinics, mothers' clubs and home nursing classes.

6. Assuming that the chief functions of the public health nurse as a health educator are executed through home visits, clinics, mothers' clubs and home nursing classes, she is limited to so restricted an area of subject matter that little contribution can be made to the program of health education in the community.

7. Home visits by the public health nurse should be curtailed and time used for group instruction in clinics.

8. The accumulation of knowledge concerning the conditions under which families live has permitted the development of a technique of family health service so that home visits are no longer needed.

This article will undoubtedly arouse wide differences of opinion among public health nursing administrators and educators. It will serve as a motivating service in the field of health education, to determine the educational outcomes desirable and the methods which the well

prepared public health nurse is qualified by virtue of her particular and unique abilities as a nurse to carry on, and thus a most constructive purpose will be achieved by Miss Blee.

ELLEN L. BUELL, R.N.

DIRECTOR, DEPARTMENT OF PUBLIC HEALTH
NURSING, SYRACUSE UNIVERSITY
SYRACUSE, NEW YORK

MISS BLEE questions some of the methods used by public health nurses in disseminating health information. Fortunately for us in public health nursing who have reached the forty-year mark, our educators no longer expect us to have degenerated past the point of being able to learn. But the writer surprises us! Have not health workers always assumed that adults had to be reached in order to effect necessary changes in health protection? For instance, our first state boards of health did not expect to enforce sanitary codes without first gaining public support. We have gone far in arousing public opinion in effecting protective laws. We still continue to educate citizens to the needs of pasteurization of milk, to what constitutes a safe water supply, to protective measures against communicable diseases and other health safeguards. We have not yet reached the point of saturation that will permit a popular law requiring these measures. Everyone engaged in public health work knows that we have to work hard to hold the ground gained over the past twenty years. We have to enlist constantly the good will of other agencies also interested in some aspect of health—the schools, welfare agencies, service organizations. We have learned, in order to reach those who hold the purse strings, whether it be for a milk ordinance, a safe water supply, a sewerage disposal plant, a hospital, a safe playground or a county-wide immunization program, that we have to convince the intelligent adult population of this need, not the indigents who do not pay the bill anyway.

School nurses in high schools and colleges have an opportunity for directing health education programs based on sound medical science for students. We need to keep these students in mind when planning our "propaganda programs." They can with the latest information at hand be very helpful interpreters. We agree with Miss Blee that we teach health rules—"beatitudes"—to children without providing the necessary resources for carrying out these health practices. But would parents have provided these essentials if the children did not have a receptive attitude toward them, if they had not joined teachers in the request for hand

HEALTH EDUCATION

washing equipment, school lunches, recreation facilities, and loan funds to care for correction of teeth and eyes? Children enter into the making of many more decisions today than they did a generation ago. A good example of this is their acceptance of tuberculin tests, health examinations, protective immunizations, nutritious foods, and selection of clothing. High school girls of yesterday are mothers today. They are doing a good job, not because they remember minute details of what they learned in mothercraft classes, but because they learned how to look to their physicians for guidance and take pride in their own efficiency.

The maternal attitude of some nurses who are always trying to do things for people can be shifted to the more modern maternal pride in seeing her proteges develop to the point of doing for themselves. They can, for example, make their own community studies. This has been done to good advantage in Minnesota as well as in many other states by nursing advisory committees. Such assistance and participation by interested citizens has helped to show how the responsibilities of several agencies overlapped or dovetailed.

Group education has been fostered as a sound means of disseminating health information when there is only one public health nurse in a county with a large population. Success of a group ed-

ucation program will depend to a large degree on what cooperative efforts are worked out with already existing groups such as farm bureaus, churches, clubs, parent-teacher and other clubs. A new opportunity for public health nurses is being opened through local civilian defense councils. This will bring more women into the public health nursing field as volunteer helpers. These women will learn how to be of assistance to their local public health agency.

The part the public health nurse plays as an interpreter to individuals is still quite necessary. Physicians have too many acutely ill patients to answer patiently all questions that the mother of the apparently well child asks. If the busy physician has confidence in the ability of the public health nurse, he will leave much to her judgment, knowing that she will recognize symptoms that require his study. This plan of team work makes it possible for physicians to see more patients than would otherwise be possible at this time when there are fewer physicians to care for patients whether they are indigent or not. The public health nurse is learning to use lay people as interpreters on current health information and community resources.

ANN S. NYQUIST, R.N.

ACTING DIRECTOR, DIVISION OF PUBLIC HEALTH
NURSING, MINNESOTA DEPARTMENT OF HEALTH,
MINNEAPOLIS, MINNESOTA

THE AMERICAN JOURNAL OF NURSING FOR AUGUST

U. S. Cadet Nurse Corps.....	Lucile Petry, R.N.
The Senior Cadet Nurse.....	Eugenia K. Spalding, R.N.
The War Manpower Commission	
Trench Foot, Shelter Foot, and Immersion Foot.....	James C. White, (MC) U.S.N.R.
Caudal Analgesia and Anesthesia.....	Z. B. Newton, M.D., and Mary R. Petkauskos, R.N.
Simplifying Nursing Procedures.....	Jean Barrett, R.N.
Personnel Practices.....	Milada C. A. Botten, R.N.
Marin City Saga.....	Jean C. McGregor, A.N.C.
Training on Bivouac.....	Rhoda E. Frid, A.N.C.
Training of WAVES for Hospitals.....	Esther L. Schmidt, N.N.C
Military Nursing in Canada	
Registered Negro Nurses in the U. S. A.....	Henrietta Landau, R.N.
The Outlook for College Education.....	Aaron J. Brumbaugh

Nurse Placement Service

N. P. S. announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom, consent to publish these has been secured in each case from both nurse and employer.

PLACEMENTS

- Mary E. Ingoldsby, consultant in industrial hygiene, State Department of Health, Charleston, W. Va.
- Edna Yates, staff nurse, Toledo District Nurse Association, Toledo, Ohio.
- Ruth Roeben, staff nurse, Henry Street Visiting Nurse Service, New York, N. Y.
- Mrs. Anne Leitz Frost, industrial nurse, Petrol-agar Laboratories, Inc., Chicago, Ill.
- Mrs. Helen M. Pittman, industrial nurse, Con-tour Saws, Inc., Des Plaines, Ill.
- Mrs. Gladys B. Tischer, industrial nurse, Industrial Metal Fabricator, Chicago, Ill.
- Zelma Elmore, industrial nurse, Midland Ord-nance Foundation, Decatur, Ill.
- Mrs. Charlotte K. Erickson, industrial visiting nurse, Eversharp, Inc., Chicago, Ill.
- Mrs. Helen Rose Kittredge, industrial nurse, Standard Transformer Corp., Chicago, Ill.
- Rosemary J. Maiers, industrial nurse, Edward Katzinger Company, Chicago, Ill.
- *Mrs. Blanche L. Vincent, assistant college nurse, (part time) Whitman College, Walla Walla, Wash.

As publishable placements this month show a preponderance in industrial nursing, a few observations regarding the current status of that field may be of interest. There is no vast increase in number of these vacancies by comparison with a year ago, although there are of course more opportunities than in the prewar years. It is expected that the postwar period will see a reduction. There have been increasing numbers of nurses who register exclusively for industrial nursing, which is a bit

unfortunate since the needs in other fields are even greater. Registrants' restrictions as to hours make it impossible to place all those who are interested. As industries are now working 24 hours a day, nurses are needed for evening and night shifts as well as the preferred day hours. Real difficulty is experienced in filling other than day shifts, despite the large number of candidates. Some industries conduct a rotating service. Thus each nurse may have her turn on each of the shifts. Registrants' restrictions as to locality also interfere with placements. Industrial plants are frequently located on the fringe of large cities or in smaller, isolated communities so that transportation may be a problem. Generally nurses are only interested in short travel and await a job to develop in their immediate vicinity. Where there is no door-to-door transportation at a late hour, some employers provide the nurse with responsible escort to or from the nearest transportation station. Positions for men nurses in industries are fewer than formerly.

Salaries in industrial nursing positions filled during June 1943 have averaged about \$150 a month for a 40-hour week, including eight hours overtime, usually paid at the rate of time-and-a-half. Not all positions require overtime, however. Occasionally there is a call for an industrial nursing supervisor in a large plant or a consultant in a state program, but there are few eligible candidates. Previous experience in industrial nursing and other qualifications are required. Some positions require public health nursing background; for staff positions good clinical or surgical experience are assets.

ANNA L. TITTMAN, R.N.
EXECUTIVE DIRECTOR
NURSE PLACEMENT SERVICE

*The NOPHN files show that this nurse is a 1943 member.

Reviews and Book Notes

LET'S TRY THINKING

By Ival Deering. 199 pp. The Antioch Press, Yellow Springs, Ohio, 1942. \$1.50.

In "Let's Try Thinking," the author analyzes afresh the need for group thinking in a truly democratic society and offers valuable suggestions to group leaders for perfecting their leadership methods through studied experimentation. Her enthusiastic and practical approach to the subject is both refreshing and encouraging to those working as group leaders. She revitalizes the values of group discussion to the individual members of the group and renews the reader's conviction that free expression of opinion by each participant promotes the most effective group action. In the latter part of the book she illustrates her suggestions in relation to various types of organizations and different groups of people.

The author's style of writing makes the content as enjoyable to read as the book is helpful.

DOROTHY RUSBY, R.N.
New York, N. Y.

MENTAL ILLNESS: A GUIDE FOR THE FAMILY

By Edith M. Stern with the collaboration of Samuel W. Hamilton, M.D. 134 pp. The Commonwealth Fund, New York, 1942. \$1.

This book is a boon to public health nurses who fight against superstitions which stubbornly cling to mental illness. Simple and readable, it can be placed, in most cases, directly in the hands of the bewildered family struggling for a wholesome grasp of what modern care and treatment demand. The nurse's security in interpretation will be fortified after she has digested the approach which the author suggests to myriad practical details (of taking the patient to the hospital, creating an attitude which will aid the pa-

tient to adjust, of accepting recommended treatment, of maintaining relationship not only during the stay in the hospital but in the critical time of the patient's return). Baffling questions in this unfamiliar field into which the family is thrust are answered with casual, natural ease which robs the situation of fear.

Insanity is explained in such non-technical terms that the family almost unconsciously comes to realize basic concepts, that is, there is no panacea for mental illness; mental disease has many forms, many causes; recurrence of mental disorder is not inevitable and the like. The vivid first hand experiences of the author in her widespread survey of mental hospitals are reflected throughout the text. This gives her statements authority and the assurance that her study has been conducted under the best auspices. Nor has she limited her observations to facts. She foresees how the family will *feel* and offers a guide of sensible suggestions in meeting various stages in this emotion-charged situation.

This book is far too realistic to give a Pollyanna impression but no reader can fail to be uplifted by the hopeful encouragement that scientific attack offers.

KATHERINE BROWNELL OETTINGER, R.N.
Scranton, Pennsylvania

A SURGEON'S FIGHT TO REBUILD MAN

By Dr. Fred H. Albee. 349 pp. E. P. Dutton and Company, Inc., New York, 1943. \$3.50.

This is a book which is full of action from beginning to end. It is an account of one man's life that has been devoted to people and their physical restoration, taking into account the welfare of their minds and soul as well. Dr. Albee's

PUBLIC HEALTH NURSING

grandfather was a cabinetmaker and a tree-grafter and Dr. Albee learned many lessons of precision and construction that were to serve him in good stead in the development of the bone-grafting technique for which he is justly famous.

Part II, "The Witch's Brew," is most timely during this second World War. This section gives an excellent picture of the activities of the author regarding orthopedic care and rehabilitation during and after the first World War. He graphically describes the organization of the U. S. General Hospital No. 3 at Colonia, New Jersey in 1917. He considered "not only plans for the medical and surgical programs but also provisions

for psychological rehabilitation of the wounded."

From postwar rehabilitation the book takes the reader to the author's activities in conserving the human resources of the country in industry in time of peace. The latter part of the book is devoted to Dr. Albee's travels and experiences in the interests of building up good relations with other countries.

This book will be of interest to doctors, physical therapists, nurses and all others who are interested in the restoration of people to their fullest activity and usefulness.

MARGARET S. AREY, R.N.
New York, N. Y.

RECENT PUBLICATIONS AND CURRENT PERIODICALS

WARTIME

HANDBOOK OF EMERGENCY WAR AGENCIES. Office of War Information. Superintendent of Documents, Washington, D. C. March 1943. 143 pp. 20c.

This handbook is a guide to all Federal agencies whose functions are devoted to the prosecution of the war.

RELATIONSHIP OF THE ARMY AND NAVY, THE U. S. PUBLIC HEALTH SERVICE, THE OFFICE OF DEFENSE HEALTH AND WELFARE SERVICES, AND THE AMERICAN SOCIAL HYGIENE ASSOCIATION IN VENEREAL DISEASE CONTROL. *Journal of Social Hygiene*, 1790 Broadway, New York. February 1943. p. 6. 35c.

FREEDOM FROM WANT: A World Goal. Elizabeth E. Hoyt. Public Affairs Committee, Inc., 30 Rockefeller Plaza, New York. May 1943. 31 pp. 10c.

This pamphlet is based on a number of studies made by the International Labor Office, the League of Nations, the Pan-American Union and other agencies into the nature and distribution of want throughout the world.

THREE REPRINTS from *Survey Midmonthly*. Survey Associates, Inc., 112 East 19 Street, New York 1943. Reprint 5c.

Freedom from Want. Eveline Burns. April. Two American Security Plans. Rilla Schroeder. April.

The NRPB and Beveridge Reports. Beulah Amidon. May.

A BLUEPRINT: THE V PLAN. Prepared by the Medical Administrative Service, Inc., 1790 Broadway, New York. 1943. 24 pp. Free.

GENERAL

DIETARY RECOMMENDATIONS FOR BLOOD DONORS. Dorothea F. Turner. *Journal of the American Dietetic Association*, 620 North Michigan Avenue, Chicago. May 1943. p. 336. Reprint 15c.

MEDICAL CARE AND COSTS IN RELATION TO FAMILY INCOME. Helen Hollingsworth and Margaret C. Klem. Federal Security Agency, Social Security Board, Bureau of Research and Statistics, Washington, D. C. March 1943. 219 pp.

This memorandum is a statistical source book including selected data on characteristics of illness and has been prepared for the use of the staff of the Social Security Board for a limited circulation to other administrative and research personnel concerned with the subjects treated therein.

NOTES FROM THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

MRS. McGRATH RESIGNS

That Mrs. McGrath has resigned from the NOPHN to return to her family and her former industrial position with the Powers Dry Goods Company, Inc. in Minneapolis is a source of regret not only to the NOPHN staff but to the many friends she has made throughout the country during her short term as industrial nurse consultant. Mrs. McGrath's interest in the Industrial Section, however, will continue and, with characteristic generosity, she already has agreed to cover for the NOPHN certain meetings and conferences in her area. Her close association with her successor for many years means that there need be no break in industrial service to our members and agencies.



Heide L. Henriksen

NEW INDUSTRIAL CONSULTANT

Minneapolis and the NOPHN Industrial Nursing Section seem fated to be closely linked together, for Mrs. McGrath returns there and Heide L. Henriksen comes from there to become the new NOPHN industrial consultant. Miss Henriksen is a graduate of the Presbyterian Hospital Training School in Chicago and has a B.S. degree from the University of Minnesota. She has also studied at Columbia University, so that New York City is an old friend. Her experience has included employment as staff nurse with the Minneapolis Visiting Nurse Association and industrial nurse with the Twin City Lines in Minneapolis from which she has obtained a leave of absence. She has given special lectures in the public health nursing course at the University of Minnesota and at Minneapolis hospitals, and

has been president of both the Minneapolis Unit of the Minnesota SOPHN and of its Industrial Nursing Section. Her career has also included vocational counselling of senior students in the high schools of Minneapolis and a succession of Red Cross home nursing and first aid classes.

The NOPHN feels it is a real privilege to have as industrial consultant one who has such a broad background in both industrial and public health nursing.

MISS TOWNER'S RESIGNATION

The attractive new lunch room and lounge which the NOPHN staff shares with other nursing organizations at 1790 Broadway was the scene of a farewell tea given in honor of Isabel L. Towner who retired July 1 as librarian of the National

PUBLIC HEALTH NURSING

Health Library. Miss Towner has guided the reading of public health nurses and other health workers since 1921 when she became librarian of the National Tuberculosis Association. She has also been editor of the *Education Index* and has done further library work with the Smithsonian Institute in Washington. When asked what she would do after her retirement, Miss Towner replied, "Rest—and then more rest." But in the fall she will become active again, doing volunteer part-time work for national health organizations including, we hope, the NOPHN.

Mrs. Eva R. Hawkins, who has been with the Library since 1925 and associate librarian since 1936, succeeds Miss Towner as librarian of the National Health Library.

ORTHOPEDIC NURSING SCHOLARSHIPS AND CONFERENCE

The National Foundation for Infantile Paralysis has renewed its grant to the NOPHN for scholarships to prepare orthopedic supervisors or consultants for public health nursing agencies. All applications for these scholarships must be filed before October 1, 1943.

A group conference on orthopedic nursing, especially planned for public health nurses actively engaged in crippled children's services, will be held in New York City October 11, preceding the annual

convention of the American Public Health Association October 12-14. Discussion at the conference will center around present adjustments in orthopedic programs and plans for postwar rehabilitation. A detailed program will be announced later. Since registration will be limited to 30, nurses interested in the conference are asked to register as soon as possible.

For information about the NOPHN scholarships and for application to attend the conference, write to Jessie L. Stevenson, Joint Orthopedic Nursing Advisory Service, 1790 Broadway, New York, N. Y.

HONOR ROLL FOR BOARDS

Boards of directors whose members are 100 percent enrolled as members of the NOPHN are to receive certificates of honor, and will be listed on a special Honor Roll in the November issue of *PUBLIC HEALTH NURSING*. If any members of your Board have been planning to join the NOPHN but have delayed doing so, urge them to join now. Then your Board will appear on the November list.

HONOR ROLL

Due to limitations of space in this issue, publication of the names of 261 agencies that have reported 100 percent staff enrollment in the NOPHN since the previous list in July has been postponed until September.

What to Read, Board and Committee Members

When a voluntary public health nursing association and a nursing bureau of a health department unite, what kind of a board does the combination agency have? Hortense Hilbert describes what a recent letter of inquiry to a sample of 40 agencies revealed about boards of combination agencies. Also, of particular importance is Gertrude Zurrer's analysis of the three

great plans for social security and health insurance—especially if board and committee members have not yet read the Beveridge and N.R.P.B. reports (how many have?). Suggested solutions for the transportation problem are given on page 479, and pertinent remarks about lay participation are included in Ann Nyquist's comments on page 470.

NEWS

Highlights on Wartime Nursing

U. S. CADET NURSE CORPS

Now that the United States Cadet Nurse Corps is an accomplished fact, it is anticipated that out of the country's 100,000 student nurses a large proportion of those who have an accelerated curriculum will join. The Division of Nurse Education in the United States Public Health Service, which will administer the Corps, is asking directors of all schools of nursing to give prominent display to posters about the Corps and to circulate informational leaflets among the students. Copies of the Bolton Act which made the Corps possible and "Regulations of the Surgeon General Governing Payment to Provide Training for Nurses" are on file at the NOPHN, SOPHN's and Nursing Councils for War Service. A limited number of additional copies are available from the Division of Nurse Education, U. S. Public Health Service, Washington 14, D. C.

SCHOOLS OF NURSE MIDWIFERY

In 1942, approximately 200,000 babies were born without benefit of trained care by doctor, nurse or midwife. With one third of our doctors joining the armed forces, the responsibility for giving expert maternity care must fall ever more heavily on public health nurses and specially-trained attendants. To provide midwife training for the increasing numbers of qualified nurses who seek to secure it, four new schools of midwifery have opened during the past four years.

All have fairly similar programs of training. In November 1939, when the declaration of war cut off the supply of nurse-midwives from Great Britain, the Frontier Nursing Service started the Frontier Graduate School of Midwifery at Hyden, Kentucky, with the special aim of training nurse-midwives for remotely rural and mountainous areas. Each class, with about four students, lasts for six months and includes delivery of at least 20 women under the supervision of an instructor, and assisting the medical director in handling abnormal cases. Nineteen students have already graduated, four are now in training and six more may enter the new class in January. Students are recruited from the staff of the Frontier Service and from nurses employed by state boards of health. Before entering the school, each student must sign a contract to remain with whatever organization sent her at least two years or for a period extending from graduation to six months after the end of the war.

In the southern states, the maternal death rate is a serious problem, particularly among rural Negroes. Many share-cropper mothers are left to the care of the ignorant granny midwife and there is a crying need for trained attendants who can provide better care during confinement.

Financed by the Rosenwald Fund, Children's Bureau and the state and county health departments, a School of Midwifery for Colored Nurses was

PUBLIC HEALTH NURSING

founded at Tuskegee Institute in Alabama in September 1941. Each applicant must be a registered nurse, a graduate of an accredited school of nursing with some public health nursing experience or training, and, if possible, some postgraduate experience or training in obstetrics. The course takes 6 months, the first week being devoted to teaching the students something about health and welfare work in general and the place of the midwife in it, the remainder to study midwife procedures in the classroom and in the field. Since the opening of the school 12 nurses have graduated.

The Maternity Center Association in June 1942 took over the old Berwind Free Maternity Clinic in New York City, formerly operated as a teaching center for medical students by New York-Cornell Medical College. Together with the Lobenstine School for Midwifery (founded in 1931) already operated by the Association, facilities are now available to train double the former number of student nurse-midwives. The course is open only to graduate nurses; gives six months of study and supervised practice in the delivery of mothers in their own homes. Graduates of the school have

gone into the far corners of the earth as supervisors, consultants, teachers.

The fourth school was started in August 1942 at the Flint-Goodridge Hospital of Dillard University in New Orleans to provide a program of nurse-midwife education for the Negro public health nurse and accordingly a source of supply of specially qualified nurses to practice midwifery in this southern region. The period of experience, also six months, is divided into three units: a series of formal lectures in the theory and practice of obstetrics to run concurrently with lectures and demonstrations in the conduct and management of labor; experience in the ante- and post-partal clinics of the hospital; and supervised field experience in at least 20 normal home deliveries, together with aftercare of mother and baby. Qualified students are earnestly being sought for this school, as the service of nurse-midwives is greatly needed in the region.

Health officers and directors of public health nursing are invited to write to any of these schools for information about the training program and the use and value of nurse-midwives in a public health program.

From Far and Near

The Battle of Transportation—The battle of transportation in the United States has so far been victorious but government agencies warn that it is still serious in most local communities and critical in all war industrial areas. Just how critical is proved by staggering figures showing that use of transportation systems in crowded American cities since December 1938 (the last "normal" year before defense work started) has increased as much as 622 percent. To avoid the necessity for establishing a system of priorities for use of local facilities the Office of Defense Transportation is redistributing buses, taxis and railroad coaches and has placed

restrictions upon the use of taxis and buses. Every one of the 2,600 sightseeing buses in the United States is now taking workers to war plants. The 93,000 school buses are being used so sparingly that most American school children who don't live more than two miles away from school are walking to and from school. Buses and taxis which once went up and down the streets of New York City (where the passenger load has increased only 2.4 percent) are now helping move passengers in crowded industrial cities.

But these measures alone will not win the battle. Car sharing and staggered hours are also

NEWS NOTES



Henry Street Visiting Nurse Service
Here's one solution of the transportation problem—but it's not recommended for hills!

imperative in order to relieve the rush-hour crush in most cities. Because buses are so overcrowded and stored cars deteriorate rapidly, government agencies are urging people to use their cars to get to work in group-riding arrangements, to recap their tires before they wear too thin, and, if they are not using their cars, to sell them. In urging car-sharing, preferably in groups of four or five, the ODT recognizes that it is not easy for several people to meet regularly twice a day, but suggests that it can be done if transportation committees are set up in each organization and place of business. So far, the best cooperation in car-sharing has come in coal mining areas where distances between home and work are often long and cars are old. Car owners who share their cars may have larger gas rations. The Office of Price Administration has instructed eastern rationing boards that "generally, one and one half to two miles each way, or a distance which can be walked in 30 to 40 minutes or less, is a reasonable walking distance," and supplemental mileage must not be granted unless the applicant is aged, in poor physical condition, or needs to carry heavy or bulky objects, such as tools.

Three hundred cities have already worked out community schedules of staggered opening and closing hours for factories, schools, office buildings and department stores in order to flatten out peak loads. In a state-wide plan New Jer-

sey has set ahead the hours of 175 public and parochial schools. More communities may be forced to stagger working hours, for it is estimated that by the end of 1943 about four times as many Americans will be going to work every day as can be carried during the usual office hours in all available public vehicles. Lack of reserve drivers to take care of rush hour traffic also makes staggered hours advisable.

According to information received from the field by the N.O.P.H.N. more and more public health nurses are solving transportation problems by going to and from work and making certain daily rounds on bicycles. The armed services have priorities on bicycles, but 283,000 new bicycles built on strictly utilitarian lines, are now available to war workers and other civilians who qualify under newly liberalized rationing regulations. Public health nurses are, of course, eligible. Applications should be made to local rationing boards.

Cost of Living—The average American now has \$1.80 for every \$1 he had to spend when the defense program began in 1940, but his money does not have the same purchasing power. The cost of living index is now about 25.1 percent above the average for 1935-1939, 24.1 percent above January 1941 (base date for the "Little Steel formula" by which raises in wages may be granted by the War Labor Board) and 7.8 percent above a year ago, according to latest figures released by the U. S. Department of Labor through the Office of War Information. For the month ending May 15, 1943, the cost of items making up 60 percent of the family budget remained practically unchanged, but food prices rose 1.7 percent, thus increasing the total cost of living for city workers by 0.8 percent for that month alone. The largest increases in May food prices were for fresh fruits and vegetables which were up 8 percent. Chicken and sweet potatoes also jumped in price. Food prices as a whole averaged 17 percent above May 1942, and 46 percent above January 1941. Aside from food, principal increases were in the cost of services, especially medical care, barber and beauty shop services.

A cost of living study made in 1942 by the N. Y. State Department of Labor finds that it costs a woman worker living alone 10 percent more than a woman in a family group to maintain the same standard of "health and decency."

Better Nutrition in Industry—Only through cooperative education and planning by both

(Continued on page A8)



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News

(Continued from page 479)

plant officials and community organizations can the acute problem of providing balanced nutritious lunches for war workers be solved in many areas where adequate plant cafeterias and mobile canteens are impracticable, a recent communique from the U. S. Department of Labor states. First, the worker himself must be made to realize the importance of sufficient and good food. Next, a coordinated plan for establishing better eating facilities must be worked out.

What passes for willful absenteeism, anemia, indigestion, nervous debility and work lag is often malnutrition. Even if a plant does have an adequate cafeteria and restaurant the food may be prepared in such a way that values—especially thiamin (Vitamin B₁)—are poured down the drain or go up in steam. In preparing a simple meal of meat, potatoes and beans it was found that in one plant cafeteria kitchen food value losses were as high as 92 percent. All public health nurses know that in people whose diet is deficient in vitamin B₁ fatigue, lassitude, loss of appetite, depressed mental states, muscle soreness and backaches develop, and the capacity for muscular work decreases.

Suggestions for selecting, preparing and serving food in order to conserve essential food factors, as well as consideration of special problems relating to industrial nutrition are contained in a new booklet released by the U. S. Department of Agriculture, titled "Manual of Industrial Nutrition." It also includes a comprehensive list of sources of posters, pamphlets, films and radio materials about nutrition. The booklet is available upon request from the Nutrition in Industry Division, War Food Administration, U. S. Department of Agriculture, Washington, D. C. or from any regional office of the Food Distribution Administration.

Adolescents in War Jobs—Responding to the need for more manpower in industries and lured by the prospect of high wages, approximately one half million 14- and 15-year-old boys and girls, and one and one half million 16- and 17-year-olds are working either full-time or part-time, according to estimates published in *The Child*, June 1943, by the Children's Bureau. This means that 1 out of every 8 children aged 14 and 15 in the United States is working as compared with 1 out of every 16 in 1941; and 1 out of every 3 children aged 16 and 17 as compared with 1 in 6 in 1941. More boys than girls are going into industry but the rate of

PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

The New School Year: A Challenge and an Answer

THE WELL-WORN paths to school house doors throughout the country resound with footsteps once again. Some of the tramping feet reluctantly approach the last milestone in the care-free journey through school days, while others less sturdily stand for the first time on the threshold of the world outside of home and family.

Those of us who share in the preparation for life of these, our nation's children, need to ask ourselves once more how well we are doing the job.

We are alarmed and rightly so when we are told that over 50 percent of our youth at the pre-induction age are found to be unfit for service in the armed forces. To be alarmed is one thing, to act another. We can do little for those who have gone but we can do much for those passing before us and for those to come.

No phase of education is more important in the lives of the children of a nation at war than that which teaches how to attain and maintain good health. The home, the school and the community have a joint responsibility in this undertaking. No one of these can do the job alone.

We as public health nurses have a unique part to fulfill in this great task because in our small way we contribute all along the line. When we are in the home we must guide the parent in carrying out the responsibilities which rest with the family. When we are in the school, we must strive

as a part of it to provide services which will improve individual and group health through its program of self-direction. When we are out in the community we must help to harness and bring into usefulness those forces which contribute to maximum achievement by the child, the home, and the school, and help to combat those which operate to retard such achievement.

We as nurses rendering service in schools must see our jobs in this three-fold light, if we are to understand and successfully re-direct our energies toward those things which will count for most. Understanding implies an awareness of other workers and the contributions they have to make. It further implies a willingness to relinquish old or share new responsibilities as the need arises.

Certain long accepted responsibilities have taken on new significance. Our contributions to health education must be integrated with the "Physical Fitness Through Health Education" programs urged by the United States Office of Education. We must be prepared to share in the development of child care centers to care for the children of industrial workers. We must teach the wise use of available medical care and apply such teaching in our advice to parents. Renewed emphasis upon the control of communicable diseases is a "must" under present conditions. Good nutrition for all is equally important. Eyes and ears must be safeguarded and

(Continued on page 516)

Wartime Essentials in School Nursing

THE MAINTENANCE of good health among all individuals is a grave responsibility of communities in wartime. Since children of school age constitute 20 percent of the population and represent the future citizenry, it is necessary that essential protective and preventive health services be provided for them in each community.

Administration of these services involves the home, the school, the health authorities and other health agencies in the community. Their maintenance requires various kinds of public health workers which are now rapidly diminishing in number due to the demands of the armed forces. Of outstanding importance among such personnel is the public health nurse who performs a variety of services for the health of children.

In order to ensure essential public health nursing service for children of school age in the case of decreasing personnel and increasing health hazards, it is urgent that action be taken. National, state and local leadership in the fields of health and education is essential to effective action.

Teacher training institutions must better prepare teachers to take major responsibility for the health supervision and instruction of the school age child and to work cooperatively with community health agencies. When this is accomplished, public health nurses working in schools should be relieved of many non-nursing services which can and should be performed by teachers.

Since the emergency which confronts us does not allow for the normal process of change through teacher training institu-

tions, it is necessary to take direct action, namely (1) define those health services which are essentially nursing and re-allocate all others as rapidly as teachers, other paid personnel and volunteers can be given in-service training by the nurse to assume them¹ (2) pool essential nursing services in schools with those of other community public health nursing agencies to ensure more complete service to the greatest number of children with economy of personnel.²

In general, essential nursing services in schools may be stated as:

1. Giving advisory service to school administrators with reference to the school health program. This should include guidance with regard to fuller use of all community health and welfare facilities.

2. Instructing teachers, individually and in groups, concerning health services they are to perform.

3. Interpretation of health examinations to teachers, parents and children as indicated, including advisory service in utilizing all community resources to make these examinations productive.

4. Visiting homes for the purpose of interpreting the needs of the child to parents, to learn family health problems for interpretation to the school, and to assist both the family and the school in the solution of these problems.

Through further work of the School Nursing Section and the Joint Committee on Lay Participation in School Nursing, intensive investigations as to specific functions of the nurse in relation to other participants in the school health program are

WARTIME ESSENTIALS

being undertaken, a report of which will be published.

This preliminary statement is made with the hope that it may provide a starting point from which local communities can begin to analyze critically their school nursing activities and act to bring about

the greatest amount of service for the largest number of children, with existing personnel.

—BOSSE B. RANDLE, SECRETARY
SCHOOL NURSING SECTION
NATIONAL ORGANIZATION FOR
PUBLIC HEALTH NURSING

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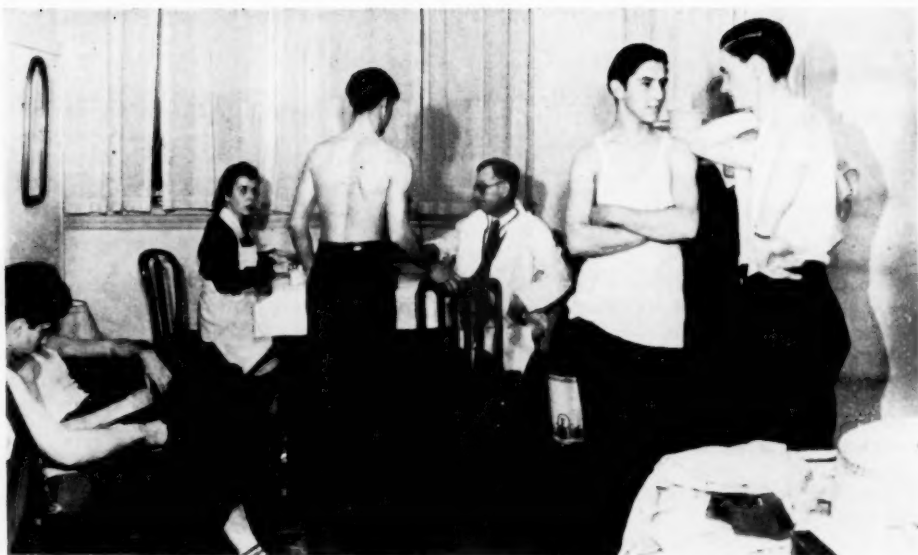
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What to Read, Board and Committee Members

Homer Folks once said, "There is nothing more satisfactory in this world than to do something for children." This issue of the magazine has to do with all kinds of things which the schools do for children to make them healthier and happier. And in almost all of these activities there is an opportunity for lay persons to help. The report of the Joint Committee on Lay Participation in School Nursing will interest board and committee members not only for its statement of goals to be reached but for the listing

of distinguished names of committee members. Articles on nutrition, hearing, seeing, day care centers all point out ways in which volunteers can help further the physical fitness of school children. On page 530 is described NOPHN's project to finance needed development of public health nursing in war communities through American War-Community Services. Endorsement by informed citizen groups before local and state war chests will do much to ensure the success of this appeal.



Pre-induction examinations of high school seniors are a wartime responsibility of the school nurse

The School Nurse Furthers Physical Fitness

By LILLIAN M. BISCHOFF, R.N.

THE DESIRE to be physically fit is great among students in secondary schools today. Students want to prepare themselves to help win this war as active members of the armed forces, efficient workers on production lines or workers in community services. To utilize this motivating force the United States Office of Education has promoted programs in high schools for "instruction and training for useful pursuits and services critically needed in wartime."¹

Three publications have been prepared by the Office of Education to help high schools gear their existing wartime programs to meet the needs and to assist other schools to organize wartime programs. The first, "Victory Corps for High Schools,"¹ describes the objectives and administrative details of the Victory Corps. The second, "Physical Fitness through Physical Education for the Victory Corps,"² provides a guide for high school principals and teachers in planning and executing the physical education phase of the program. The third, "Physical Fitness through Health Education,"^{3,4} contains recommendations for developing the health education phase.

Although the nurse working in schools is concerned with the total physical fitness program and is expected to participate in all its aspects, she is prepared to make her greatest contribution in health education. In many secondary school systems the

PHYSICAL FITNESS

health programs offer an excellent background for correlating wartime programs with those already existing.

The following outline is designed to inform the school nurse about the program of physical fitness through health education and to show how she can utilize the plan to make her services more effective. First, the nurse must frankly scrutinize and analyze the things she is now doing. These steps may be helpful:

I. MAKE A PRELIMINARY PLAN

A. Consult the school principal to learn the type of wartime program under consideration and the plans for developing the health education phase.

B. Review present objectives and activities of the nursing program and make any adjustments needed to include the additional objectives outlined in the physical fitness through health education program.

C. Study public health nursing activities involved in performing the new aspects of the job.

D. Readjust the nursing program in light of the new demands and determine those activities to be eliminated or allocated to someone else; simplify techniques and procedures and determine the most important nursing job.

E. Survey the available medical, dental and other health resources in the community and be prepared to interpret them to the school.

F. With the help of school and other personnel work out a new nursing program of action.

II. PARTICIPATE IN PROGRAM OF PHYSICAL FITNESS THROUGH HEALTH EDUCATION

There follows an outline of recommendations appearing in the Physical Fitness through Health Education manual³ and suggestions for nurse action.

Summary of Recommendations

A. Administrative provision for the total program

1. Fixing responsibility

(a) One person should be given responsibility for coordinating all school health activities and for relating them to other activities in the community.

(b) A school health committee should be organized to plan cooperatively the development of the program.

Suggested Nurse Action

(a-1) Support and assist the individual chosen by the school to coordinate health activities. The kind and amount of assistance depends upon the size and location of the community and upon the inter-relationships that are established in the school. The qualified nurse working in schools may be given this responsibility and if so she should have not only a thorough knowledge of the administrative problems involved in school health education, but she should have a working knowledge of functions of each member of the school personnel concerned with educational guidance and health service and of all functional relationships involved.

(a-2) She should know the community wartime program and she should know how to use all community resources effectively.

(b-1) Help incorporate the objectives of the wartime program in existing school health committees.

(b-2) Help stimulate the development of a school health committee in schools that have not organized one.

(b-3) Be prepared to assume additional and different functions allocated by the committee.

*Summary of
Recommendations*

2. Providing time and opportunity for health education
(a) Time should be provided in the curriculum for all students to study health problems vital to them.

(b) Opportunity for health instruction may be provided through the development of health units in other courses, integrated courses and home room programs.

3. Providing health examinations and follow-up

When possible an examination should be provided for every student taking part in the program.

(a) Check fitness for participation in strenuous physical activity.

(b) Discover defects.

(c) Find health problems requiring modification in student's daily regimen.

4. Providing school environ-

Suggested Nurse Action

(a-1) Interpret to the school personnel the community health program.

(a-2) Interpret also health problems peculiar to the community.

(a-3) Interpret the community public health resources.

(b-1) Review the health units incorporated in the school curriculum and show how home and community health activities may be utilized to correlate students' class work with active participation.

(b-2) Organize and encourage first aid and home nursing courses. Help secure qualified nurse instructors to teach the nursing aspects of the care of the sick in their homes.

(a-1) Secure data from present health records in school to evaluate health status of individual student. This should be a cooperative teacher-nurse action.

(a-2) Review health resources in the community and make an up-to-date resource file showing name, address, schedule and intake policy of agencies concerned with health and related problems. This may be an activity for a sub-committee of the school health council.

(a-3) Interpret needs for medical care of high school students to immediate superior officer.

(b-1) Instruct teachers in the techniques of making special screening tests such as vision, hearing, height, weight, posture and others.

(b-2) Help provide a physical and dental examination either from the family or school physician or from a special physician and dentist secured for this purpose.

(b-3) Instruct the teachers how to assist the physician with physical examinations.

(b-4) Manage the school clinic procedures.

(b-5) Instruct and supervise student-helpers in the management of clinic routines, clinic set-up, and other suitable tasks.

(c-1) Interpret individual medical findings to school personnel and assist and help supervise modified programs to meet the needs of each.

(c-2) Plan for office conferences to follow through on defects.

(c-3) Seek assistance from special teachers—as nutritionist, home economist, physical educational instructor and others regarding special instructions and guidance for individual pupils.

*Summary of
Recommendations*

ment conducive to health

(a) Maintain safeguards in school shops.

(b) Apply principles of health and safety in connection with activities and equipment for physical education.

(c) Provide sanitary toilets, handwashing and drinking facilities.

Provide adequate sanitary maintenance in face of depleted custodial personnel.

Provide adequate lighting and ventilation facilities.

5. Training of personnel.

(a) The best qualified persons on each faculty from the standpoint of personality and health education training and experience should be selected for leadership in health education. However, every member of the faculty should make his contribution to health education commensurate with his responsibilities.

B. Helping students meet general health objectives. The six major health objectives listed below are suggested as the basis for this wartime emergency program of physical fitness through health education.

1. Correction of impairments.

(a) Carry on extensive education programs with students and parents regarding

Suggested Nurse Action

(a-1) Study and learn the health hazards connected with shops, buildings and grounds and how accidents may be prevented.

(a-2) Visit the shops and observe how the principles of safety and health are observed by the students. Point out needs for using improved methods.

(c-1) Review the total school environment and assist with plans for maintaining safe, sanitary conditions, these plans to include student participation. Sometimes certain classes or student committees can take part in these reviews and plans, as special projects.

5. The teacher is the first *line of defense*. The nurse should make every effort to help her become more effective in preventing and in dealing with health problems.

(a-1) Give consultation service to teachers relative to health needs of individual students and of the school as a whole.

(a-2) Provide pertinent scientific health literature for the faculty and for use in the classroom.

(a-3) Assist with securing home nursing and first aid teachers for the faculty.

(a-4) Participate willingly in in-service training programs for teachers.

(a-5) Informally give consultation services to the faculty.

B. The six objectives listed under "B" have always been primary objectives of a school health program. The emphasis given to them today makes it imperative that steps be taken now to prevent a repetition of the findings of the first draft.¹

It is recognized that with the shortage of doctors and nurses in the community, it will be increasingly difficult to secure assistance needed to correct all the physical impairments. The nurse, with the assistance of her supervisor and other advice from the official health agency, should be able to use available resources to very best advantage.

1. The exact plan of action should be an outcome of administrative and group planning.

(a-1) Assist the teacher to interview each student found to have a defect and help him to make definite plans for securing correction. Devise a reporting system whereby

PUBLIC HEALTH NURSING

Summary of Recommendations

the importance of corrections and means of securing them.

(b) Discover and utilize community resources. . . .

(c) Give particular attention to visual and dental defects.

2. (a) Pay particular attention to the common cold, tuberculosis and smallpox and to other diseases as individual needs are indicated locally.

Suggested Nurse Action

the student will be responsible for informing his examining physician of the physical findings in the school, and one in which the report from the examining physician may inform the school of the medical recommendations.

(a-2) Interpret the medical findings and specific plans for correction to the principal and teachers and make plans for definite reports of progress in the follow-up.

(a-3) Set up a date file as a system for following through on the plans for corrections.

(a-4) Provide a periodic statistical report of progress of follow-up for the principal, for the health committee and for the nursing supervisor.

(a-5) Provide an appointment system in school for parents, teachers and students to discuss individual problems. This time may be set up before and after parent-teacher meetings, evening school or at a time when parents are not at work.

(a-6) Plan parent group discussions where common problems indicate need.

(b-1) Visit clinics, physicians and dentists in the vicinity and interpret the school health program to them, to seek "priority" for care of physical defects among high school students.

(b-2) Interpret medical recommendations to the school personnel and secure adjustment of school programs to meet the situation. Interpret the specific student need to the community group best fitted to help meet it, so that adjustments can be made.

(b-3) Get in touch with agencies concerned with providing financial assistance to families and help families secure aid for students as needed.

(c-1) Secure periodic reports of student surveys of class rooms; tests of light and glare; observe teacher and student practice of the principles of sight conservation.

(c-2) Secure specific orders from examining physicians regarding adjustments needed for individual care of students and interpret these orders to teachers.

(c-3) Point out the need for better understanding of adequate general medical care for students with visual impairment or dental defects.

(c-4) Point out opportunities for incorporating eye and dental health in the curriculum.

2. (a-1) Provide the school with health department regulations designed to control communicable diseases, and interpret them to school personnel.

(a-2) Keep the school informed regarding the incidence of communicable diseases in the community.

(a-3) Help provide data relative to illness as a cause of absenteeism.

PHYSICAL FITNESS

Summary of Recommendations

(b) Educate students regarding the causes of these diseases, how they are spread and how prevented.

(c) Secure immunization as recommended by health authorities.

(d) Encourage and expect students to remain home at the beginning of a cold. . . .

(e) Utilize the program of tuberculin testing and X-ray examination to discover students in contact with tuberculosis.

(f) In malarious belts . . . work with authorities on control programs.

(g) Provide isolation in school for conditions that may be infectious.

3. Selection of an adequate diet.

(a) Educate students regarding basic daily food requirements.

(b) Encourage them to improve personal nutritional status . . .

(c) Make sure that the school lunch provides its share of daily food requirements and that each student gets an adequate noon meal.

(d) Give opportunity for students to help in essential wartime measures of food conservation and production and family and community feeding.

Suggested Nurse Action

(b-1) Provide up-to-date scientific facts regarding cause and prevention of communicable diseases. Utilize current incidences to make teaching dynamic.

(b-2) Help teachers secure health education visual aids on communicable diseases such as moving pictures, slides, etc., to be used in the classroom as an aid to learning.

(b) Help provide opportunities for students to participate in school projects or community programs designed to control communicable diseases.

(c) Take active steps to provide immunization for each student according to the advice of the local health officer and the school authorities.

(d-1) Encourage teachers to place responsibility for remaining at home upon the student when his cold symptoms appear.

(d-2) Assist student to understand why he should isolate himself and how he can protect members of his family.

(g) Assist the teacher to demonstrate the principles of isolation in the school and in the home as a part of her class room instruction.

(a) Learn the food habits of each student who comes to your attention and assist him to develop proper food habits.

(b) Help secure adequate medical care for students considered to be below par, with possible nutritional deficiencies.

(c-1) Learn food habits of school children by eating with them.

(c-2) Plan ways of assisting parents with individual school lunches or getting their help in making lunch room facilities and luncheons more adequate.

(d-1) Participate in wartime community food projects and interpret opportunities for student participation.

(d-2) Encourage victory gardens.

(d-3) Help students to understand government rationing and price control programs.

(d-4) Work with parents individually or in groups to interpret food requirements of students and lend assistance in securing essential foods.

PUBLIC HEALTH NURSING

Summary of Recommendations

4. Prevention of accidents and assistance in giving emergency care.
 - (a) Provide planned instruction in accident prevention.
 - (b) Provide organized training in first aid.
 - (c) Provide instruction for all girls in home nursing and care of the sick and for as many boys as can arrange to take the instruction.
5. Daily program planning to provide a balance of work, exercise, recreation, rest and sleep.
 - (a) Help each student budget time to provide such a balanced program.
 - (b) Provide time during the school day for rest and relaxation.
6. Development of a sound mental attitude.
 - (a) Provide counseling service for students which will help each to find his place in useful war service.
 - (b) Encourage students to participate in community war efforts so they may have a sense of contributing actively. . . .
 - (c) Provide instruction in mental hygiene so that students will have better understanding of their own reac-

Suggested Nurse Action

- (a-1) Encourage school participation in home and safety activities.
 - (a-2) Assist with planning home and school accident hazard surveys.
 - (b-1) Help secure qualified instructors to give first aid instruction to school faculty.
 - (b-2) Help secure first aid materials and equipment needed in the school.
 - (c-1) Find the inactive qualified nurse in the community who may be available for teaching home nursing.
 - (c-2) Assist with instruction of home nursing classes.
-
- (a-1) Discuss the student's daily regimen during interviews relative to health, as indicated.
 - (b-1) Interpret need and assist with establishing an attractive student rest room in the school.
 - (b-2) Interpret need for adequate community recreation programs.
-
- (a-1) Interview students who show symptoms deviating from accepted behavior patterns and help plan for immediate adjustments.
 - (a-2) Give accurate report of observation and school findings to the physician.
 - (a-3) Help prevent problems by helping the student secure correction of all remediable defects.
 - (a-4) Interpret physician's findings and take the initiative for adjustments for handicapped children.
 - (a-5) Help secure adequate medical care for students showing signs of psychoses and neuroses.
 - (b-1) Help investigate community wartime programs in which students may participate satisfactorily and with safety for the students.
 - (c-1) Assist teachers to become aware of the early manifestations of maladjustments.
 - (c-2) Interpret individual family relationships to the teacher for better understanding of student problems.

PHYSICAL FITNESS

Summary of Recommendations

tions and those of others in
time of stress, and may be-
have more intelligently.

Suggested Nurse Action

III. ASSIST STUDENTS TO MEET HEALTH OBJECTIVES FOR MEMBERSHIP IN THE FIVE SPECIAL SERVICE DIVISIONS

Before entering adult war service a high school student should show satisfactory progress in attaining the objectives described in the preceding section. In addition he should have an understanding of the particular problems of his chosen area of service and its health demands.

The physical fitness through health education programs provide for this preparation in connection with health classes, vocational training and other organized training for the special services.

*School's Responsibility for Preparing Students for Service in:*³

1. Air, Land and Sea Service Division.

(a) Help each student evaluate his own health in light of Selective Service health requirements and assist him in correcting his deficiencies.

(b) Give instruction and as much experience as possible in civilian life in the military aspects of hygiene. . . .

2. Production Service Division.

To prepare students to meet those special health problems associated with industrial and agricultural work.

(a) As a part of industrial training to help them develop sound health and safety attitudes and practices through instruction on such problems as exposure to heat and glare, industrial poison, flying particles, electricity, hand tools, noise and general health practices of the worker on the job.

(b) As a part of agricultural training to help students develop sound health and safety attitudes and practices by instruction in such problems as farm sanitation; farm accidents; excessive heat; poisonous plants, snakes and insects; and general health practices of the worker on the job.

Suggested Nurse Action

(a-1) Learn the health requirements for admission to each of the military service divisions and assist teachers with interpretation of these requirements for individual students.

(a-2) Proceed as in II, B, 1a, b and c (See pp. 487-488).

(b-1) Assist with locating and evaluating visual education materials showing military aspects of hygiene.

(b-2) Help secure health films and up-to-date scientific literature on this subject for the school.

(b-3) Interpret and assist with plans for immunization as advised by the Health Officer.

(a-1) Learn up-to-date methods used by industry to prevent health hazards. Actively participate in prevention of accident program in the schools, home and community.

(a-2) Assist the school in first-aid programs to help students help themselves in case of accident.

(a-3) Assist guidance personnel to help students select work assignments suitable to individual needs and aptitudes.

(b-1) Contact the public health nurse in the community where students are assigned to work and seek her cooperation and help in providing health services for students during their stay on the farm.

(b-2) Stress the importance of securing dental corrections.

(b-3) Re-emphasize the importance of immunization for typhoid fever, smallpox and other diseases recommended by the health officer and

PUBLIC HEALTH NURSING

Summary of Recommendations

- 3 Community Service Division.
 - (a) Safeguard the health of students engaged in community service work through seeing that the work is carried out under sanitary conditions and that the students' health is supervised.
 - (b) Provide training which will help students prepare adequately for services. Training for services in health should give emphasis to
 - (1) child care and extended school programs . .
 - (2) home care of the sick
 - (3) school feeding
 - (4) school and community sanitation
 - (5) clinics

Suggested Nurse Action

- school authorities. Assist with immunization programs.
- (b-4) Strengthen the teachers' instruction relative to eating habits.
- (c-1) Assist teachers and students to make plans for active participation in useful community services commensurate with individual capabilities.
- (a-2) Emphasize the importance of providing adequate supervision and protection of student health.
- (a-3) Assist the school to interpret the capabilities and limitations for student participation.
- (b-1) Assist teachers with student instruction in caring for the health needs of small children, such as health inspections; bathing; guidance of daily regimen; procedures used to protect one's self and others from colds and other communicable diseases; how to prevent accidents and what to do in case of injury.
- (b-2) Instruct and assist teachers with student instruction in procedures used to care for non-communicable chronically ill and aged persons in the home, such as giving a bed bath; taking temperature and pulse; keeping a record; improvising equipment and following directions of the physician and the visiting nurse.
- (b-3) Give assistance to the nutrition teachers, cafeteria managers. Help students utilize this service to improve and correct deficiencies due to nutrition.
- (b-4) Study the sanitary conditions in the schools and assist teachers and students with action needed to improve the school's sanitation. Interpret community sanitary programs and help secure the students' participation in such sanitary programs as malaria control activities; rat control and sanitary surveys.
- (b-5) Use students to assist with planning and operating school clinics in the secondary and elementary schools.
- Assist with instruction in techniques used in health promotion and disease prevention clinics

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- ³ "Physical Fitness through Health Education for the Victory Corps." Summary of Recommendations for the School's Responsibility. *Education for Victory*, February 1943, p. 13. Superintendent of Documents, Washington, D.C.
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A community can have this . . . or this
 —children of war-working mothers playing dangerously alone in the streets, or children
 daily placed in child service centers, their health and safety under expert supervision

Preventing Child Casualties on the Home Front

By DOROTHY B. NYSWANDER, Ph.D.

THE HOME front is united at least on two points: It wants to win the war as soon as possible; it doesn't want its children to be casualties of war production. With the number of employed women (excluding agriculture) increased from 9,700,000 in June 1940, to 14,400,000 as of June 1943, it is inevitable that hundreds of thousands of women with young children have gone to work. It was understandable then that the Congress should be alert to the needs of these mothers and provide funds for the care of their children.

Under the Lanham Act of 1941 Congress provided funds for housing, schools, hospitals, water mains, sewer lines and

recreation facilities where immense and sudden shifts in population overwhelmed the communities in which defense industries were springing up almost over night. The whole program for orderly living in many localities was desperately dislocated. Then before the newly arrived workers could leave trailer camps, tents and even the makeshift shelter of ancient boxcars and barns, there came the movement to and concentrations in the new military camps.

Under the Federal Works Agency a vast construction program got under way. The Agency was specifically charged with making life bearable in scores of communities which found their utilities and

PUBLIC HEALTH NURSING

their resources utterly inadequate under the emergency impact.

Care of children of the women who were donning slacks to work in the shipyards and airplane factories; care of the children of women replacing the drug-store clerks, elevator operators and street car motormen; care of the children of women who now were returning to the nursing and teaching professions which they thought they had left forever; care for children needing not only supervision of their play activities but physical care as well if mothers were to stand with fathers on the production line was demanded from East, West, North, South.

Thus it was in August 1942 an allotment of federal funds was made to the Board of Education of New Haven, Connecticut, for the first war nursery and the first child care center for the young children of the mothers who had joined the growing army of industrial workers. Since then 3,570 centers have received federal allotments to assist the local authorities in maintenance and operation of the child care facilities. California leads the states with 485 centers. On July 31 provision had been made for the care of 200,000 children to be enrolled in this child care program.

Mrs. Florence Kerr, director of War Public Services of FWA, predicted on July 30 that the agency would be able to meet the great and increasing need for child care. She added that the program contemplated such care for at least a million children of mothers employed in work essential to the war.

In many communities providing nursery school care, no great new problems were present. The Work Projects Administration during the depression had employed surplus teachers to develop this type of school. Technical advisory experts in the field of nursery school education had established standards for teachers and techniques of operation. Nursery school

education became a part of the educational system in many places.

No such preparatory work had been done, however, to help communities draw up the blue prints for a before-and-after school program—a twelve-hour program—for the school age child. Quite naturally, therefore, many boards of education and superintendents of schools raised the question, "Is a program which starts with breakfast at 6:30 in the morning and ends with supper at 6:30 in the evening the responsibility of the school system?" The local child care committees and the defense councils in the various communities have answered, "Yes."

Now a majority of the wartime child care programs (nursery school and school age) are an integral part of local school systems to which the Federal Works Agency has granted Lanham Act funds to cover approximately 50 percent of the operating costs of the special services.

There are an increasing number of communities, however, which are developing day nurseries under the sponsorship of private agencies, parochial schools and welfare departments. These also receive federal grants of money under the same conditions as when boards of education operate the program.

WHAT ARE these conditions? Every public health nurse should know the answer to this question. As a community worker she cannot afford to be ignorant.

First of all, the locality requesting funds must be one in which a shortage of labor exists or impends. The work of women is needed. And if the only available women are those with children, the care of these children is essential so that mothers may go to work with a mind at rest, knowing their children are in good hands.

Second, the private (non-profit making) or public agency requesting federal funds must not ask for more than 50 percent of the operating costs except in special

PREVENTING CHILD CASUALTIES

cases such as where the wages of women workers are very low. In these places, if the justification warrants, a federal contribution not to exceed 66⅔ percent may be requested.

Third, the applications from any local group must carry the comments of the proper state agency so that state education and welfare authorities will not be unaware of the efforts of localities within the state to meet their child care problems.

Fourth, the community must be in back of the plan proposed to care for the children. The child care committee, usually a subcommittee of local defense councils, makes a plan for all the children in the community. The application for federal funds to care for children of working mothers is only a part of this. This committee acts in an advisory capacity to the agency making the application for funds.

The kind of care provided children in the wartime centers is the direct responsibility of the agency receiving the federal funds. This means that the supervision, selection of personnel, provisions for nursing and medical care, precautions to insure a safe and sanitary environment, provision of adequate nutritious food and the development of an intelligent program based on knowledge of how child "growth" takes place, depend upon the insight and leadership within the community.

THE HEALTH care of these young children of working mothers is an all important phase of the program. What are communities doing about it? Our present experience shows no single pattern for using the nursing and medical resources, whatever they may be, in planning and providing health services. In many places a representative of an official or nonofficial public health nursing agency is a member of the child care committee. As a member she directs attention to the over-all health problems of the children

in the community. She also is in a position to know what nursing services the community can contribute to the center so as to keep the operating costs as low as possible; and what nursing services must be paid for if no contributed services are available.

In some localities, the community has contracted with the local public health nursing agency and pays for definite hours of nursing service. Usually this is on a part-time basis. When there are many centers in a city with a large number of children in attendance sometimes a full-time nurse is employed.

In many communities the nurse in the school has added to her regular job the task of giving professional service to the children in the wartime centers. In other places the visiting nurse association has contributed a definite number of hours each week to the center. In still others staff nurses from teachers colleges, the Red Cross, other private agencies and health departments provide nursing service without cost to the center as part of their community war activities.

The special responsibilities of the nurse in her work in the wartime centers are much the same as those of the nurse in a well-conducted school program. Two facts, however, must be kept in mind which determine the emphases the health program in the wartime child centers must include: first, the children are very young. Many of them for the first time are participating in group living. Secondly, the parents of the children are often newcomers to the community. They come from all parts of the country. Their past health histories, their participation in preventive health programs, their knowledge of modern health practices are unknown quantities.

These facts lead to the conclusion that the first safeguards must be to learn whether the child has been fully protected, prior to entrance to the center, against

PUBLIC HEALTH NURSING

smallpox and diphtheria; second, to secure an adequate medical examination of the child—one given with the parent present if possible.

The nurse in the center should develop written plans for the head teacher to follow in (1) referring children for emergency accidents or illness (2) contacting parents regarding health problems of a child and (3) readmitting a child to the center after an illness. Even a full-time nurse cannot be in the center for a twelve-hour day and in her absence teachers should know what to do when a health problem arises. The nurse should not trust to oral instructions; these should be posted and available as guides to all of the staff in the center.

The long range responsibility of the nurse serving the center, however, is to educate the staff and the children's parents to take over many of the tasks which formerly only a nurse assumed. A sound program to provide twelve-hour health supervision depends upon the ability of the nurse to recognize this as one of her most important functions.

Examples of what teachers and parents need to know include:

1. How can infections be prevented?
2. What signs may indicate the child has a communicable disease?
3. Why is isolation from other children important when the teacher suspects that a child is ill?
4. How can accidents be prevented?
5. What simple first-aid procedures should be followed before medical and nursing care can be obtained?
6. What adjustments need to be made in the daily program of children with special health problems?
7. How can health habits practiced in the centers be carried over into the home so that the school and home will not be inconsistent in what they are teaching?

Many centers are operating excellent

health programs in which the nurses are incorporating the above activities. Some, however, reflect the point of view that the nurse alone is responsible for all the details and little teacher interest in health is the natural result.

A problem as yet unsolved in many communities is how to provide care for the sick child. Failure by the community to do this means some member of the family must stay home from work. Man-power hours are lost; production is decreased; and the effectiveness of providing centers to care for children of working mothers is negated in some degree.

A GAIN it is necessary that the public health nurse help the community solve this problem. Perhaps the solution lies in training volunteer or paid auxiliary workers to help care for sick children; or in establishing services similar to the housekeeping aide program of the WPA; or in organizing women who have taken the Red Cross nursing courses. No matter what the plan the public health nurse is responsible for seeing that the problem is met and that the program is under the best supervision the community can offer.

The wartime centers for children are one of the most important developments in the nation's effort to protect the home front. These children will inherit such a world as the war leaves. The care given them now will be reflected in their equipment of mind and body and knowledge to meet the conditions of this changed world and their places in it.

Many women, many nurses, are serving in the military forces. That is essential work. But those of us who stay at home and strive to interpret the needs of children to the community, and to further the rights of children to grow and play in a decent, happy, health environment—we also serve.

The Nutrition of the School Child

By AGNES FAY MORGAN, Ph.D.

THE GRADUAL crescendo of interest in nutrition as a scientific field and a fundamental of public health has under the necessities of war become tremendously accelerated. The National Nutrition Conference in 1941 and the Conference on Food and Agriculture in 1943 are sign posts of this astonishing progress. The Final Act and Section Reports¹ of this latter conference contains clear and practical recommendations for that "marriage of agriculture and health" which was first proposed in the meetings of the Mixed Commission on Nutrition of the League of Nations. Here are no "starry-eyed" theories but far-seeing and conservative application of the newer knowledge of nutrition to the problems of feeding all the people of the world.

The Vulnerable Groups. In particular, attention is drawn to the needs of the vulnerable groups, expectant and nursing mothers, infants and pre-school children, school children and adolescents. It is suggested that governments might well, if necessary, provide additional protective foods for these groups at cost or free, and that special measures be taken to educate this part of the population in the proper choice of food. "Carefully planned mid-day meals providing at least one-third the daily food needs of the school child should be recognized as one of the greatest single steps to improve the health of the community. Special attention should be given to the inclusion in school meals of those nutrients which are lacking in the dietary, and so far as possible local foods should

be used. There is a trend throughout the world toward making school meals an integral part of free education."¹

The public health nurse is in a unique position to minister to and educate these vulnerable groups. She meets pregnant and lactating women in the welfare clinics and centers and in the parent-teacher organizations. She now has responsibilities and contacts with pre-school children in the nursery schools and she deals with school children and adolescents through the school health departments. The needs of these groups are greatly increased by wartime rationing, shortages and high prices of foods. In spite of our vaunted wealth of agricultural production, advanced knowledge of nutrition, increased incomes and public health measures the danger of damage to health and efficiency through poor feeding is likely to increase during the next year or two. For adults a relatively short period of inadequate nutrition, while not negligible, may be of secondary importance but for children it is likely to be crucial.

It May Be Too Late Sometimes. An experiment recently carried out in our laboratory will illustrate the danger of poor nutrition in growth. A group of seven young dogs were placed when they were weaned on purified basal diet, adequate in all respects except as to vitamins. All the known vitamins were given them separately in crystalline form, and in generous amounts. Thiamine, riboflavin, pyridoxine, pantothenic acid, nicotinic acid, choline, biotin, inositol, para-amino

benzoic acid, as well as vitamins A, E and D were included, that is, everything except the unknowns. Within three months all of these young dogs were either dead or moribund. One of them was removed from the experiment when in bad condition and given the best mixed stock diet at our command. The animal survived and slowly resumed growth but exhibited an exaggerated form of the intermittent hind quarters paralysis seen in all the others. After six months, growth ceased and the stunted adult dog presented the pitiable spectacle of weakness, constant trembling, imperfect teeth, unstable nerves, occasional fits and occasional paralysis of hind quarters. The source and site of this failure was unknown except that it originated in a nutritive deficiency. A relatively short period of deprivation produced permanent disabilities which the most lavish feeding could not eradicate.

Prevention first, cures if possible, is the watchword on which all will agree in regard to nutrition as well as disease. The most efficacious place and time for such preventive measures are found in the schools, for here most of the children of the community are gathered together under public supervision.

Moreover generous and intelligent feeding of school children has been demonstrated in many communities and over many years to produce improvement in the growth, health, school attendance, discipline, and learning of many children. Physical examination and measurements of school children followed by feeding of known food supplements to some and re-examination of all after varying periods has become almost standard technique in nutrition circles.

Supplementary Feeding Studies. One of the earliest studies of this sort² was done at the University of California on a group of elementary school children, com-

paring the effect of oranges and milk as supplementary foods. All of the children given either food improved, but the orange-fed group in this case grew better, probably because the home diet of these children was already well supplied with milk.

Later studies in this series^{3,4} were carried on in Oakland and Berkeley schools with improvement in the growth of nearly all the children given any of the small supplementary feedings. An orange, a glass of milk, two or three crackers, or a few figs were each of some value in supplementing the home diets.

One of the most interesting comparisons⁵ was that made in a Berkeley junior high school where 80 underweight children ate their lunches in the school cafeteria, one group eating daily ordinary white rolls and the other, rolls containing wheat germ instead of half of the flour. No other change in their food was made, but the group fed the wheat germ in every case achieved a much better rate of growth in both weight and height. The effect was probably due to the considerable B-vitamin content of the wheat germ. This study was confirmed in Canada⁶ and later still in Germany.⁷

The extensive observations made in Great Britain by Mann, Orr and others⁸ on the effect of various dietary supplements, especially milk, on the growth of several hundred school children added spectacular evidence to the story.

A Single Optimum for All Children. Orr raised the semipolitical question as to whether the optimum growth and health standards attained by children of the upper-income group and by those given supplemental foods should not be adopted for all classes. Thus, free access to the proper amounts and kinds of foods should be available to all children, possibly through the schools.

Indeed the whole question of setting

standards for the normal daily food needs of growing children has become complicated by the wide differences in growth rate of these two income groups. Which shall be set up as the necessary daily intake of calcium, phosphorus, or protein—that amount needed by the large, rapidly growing boy in a private school or by the slower growing son of a laborer?

If we agree that one of the objectives of a democracy should be to wipe out the growth differences attributable to economic and social causes, we must recognize that this can be attained only by equalizing the quality and quantity of the food available to all children. Not only economic but also educational measures are required to bring this about because intelligence in the choice of food is even more important than increased income.

Number One Requirement: Enough Food. Though many foods of high nutritive value cost no more than some of limited value, poverty increases the hazards of ignorance. An illustration of this was seen in our supplementary feeding studies previously mentioned.⁴ In a school group of poor economic status extra feeding of sugar-crackers, containing little more than increased calories, improved the weights and heights as much as did extra milk and more than did the lower-caloric orange feeding. In a school of good economic status the milk and oranges both proved excellent growth stimulants, and in an institution with carefully planned adequate diet little advantage was seen in the addition of either fruit or milk.³

The first limiting factor in the growth of the poorest group, therefore, was the total amount of food and until this lack was met no further improvement could be obtained by use of the protective foods. In the groups of higher economic status the calorie intake was apparently adequate and the rate of gain "normal," but

when sufficient growth-stimulating food was added the rate of gain was nearly doubled. Which rate of growth of these children should be accepted as "normal"? When the full advantage of even our present knowledge of nutritive needs and our abundant food production and distribution is made available to every child, new "normals" far above the present will surely be established.

The Oslo Breakfast. Adding even small supplements to the daily diet of school children, then, can measurably improve their nutrition, and provision of well-planned lunches or breakfasts can make an even greater contribution. The "Oslo breakfast" which was provided for a decade before the current war to all school children in Norway, demonstrated its value abundantly in better school attendance, performance, and spirit.

I saw in 1931 the children in a large public school in Oslo march into their classrooms and delightedly eat the food spread out on their desks. It consisted of milk in a 12-ounce bottle, a large chunk of dark whole-grain bread, another chunk of a dark whey cheese, and a long, clean, raw carrot. No dishes and no cooking were involved, and only a straw and a paper napkin were used for table accessories. But the appearance of those healthy, lively boys and girls indicated the success of the plan.

The composition of the meal is what affects the nutrition of the child, not the fact that it is hot or cold, cheap or expensive, breakfast or lunch, served in fine or poor surroundings. The Oslo breakfast which I saw served could hardly have been bettered in a nutritional sense no matter how much more it might have cost, and it might easily have been damaged by fancy cooking and serving. The only change in the menu which can now be suggested grows out of our vastly increased knowledge of the distribution of vitamins

PUBLIC HEALTH NURSING

in foods. The carrot provided very poorly the ascorbic acid (vitamin C) for which no doubt it was included. A raw rutabaga or a few cabbage leaves would now be chosen.

When There Are Surplus Foods. In an effort to save farmers from economic ruin, the federal Surplus Marketing Administration in 1935 adopted a farseeing plan for the provision of lunches for school children from some of the surplus foods. The schools were expected to underwrite any expense involved in cooking and service, but the Work Projects Administration came forward to shoulder most of the burden, even as to supervision.

Nevertheless, in some communities school administrators demurred against the introduction of the program on the ground that no cooking and serving facilities were available. Perhaps there has been too much talk about the *hot* school lunch and too much emphasis on the social aspect of the meal.

According to a report made by the Work Projects Administration in 1942, during the preceding year one million school children in 45 states received an adequate lunch daily served by 36,000 women employed by that organization. At the peak of the service in March 1941 about two million children were served. That the benefits to agriculture as well as to the children are considerable was pointed out in a report on the school lunch program and agricultural surplus disposal prepared by the Bureau of Agricultural Economics in October 1941.⁹

Some provision for the continuation of this important program is planned by the Food Administration but obviously not from surplus foods.

Which Children Need Help? Some means of screening out the most nutritionally needy children, regardless of economic status, must be found whenever

a limited program of feeding is contemplated, as may now be necessary.

A large amount of literature has developed around the problems involved in basing such judgments upon objective evidence. Determination of weight and standing height was the first and most obvious device, and so-called "norms" for these measurements for age and sex were set up as a result of observations upon many thousands of public school children. The Baldwin Wood standards are the best example of these. Many difficulties have arisen in the use of these norms chiefly because they allow too little margin for the widely varying builds of racial stocks, for the periodic character of the growth curve, and for fluctuations in body composition.

Numerous other biometric proposals have been made for better judgment of the nutritional condition of children, including the well-known arm-chest-hip index.¹⁰ Vital capacity, grip strength, and endurance tests have also been used with varying degrees of success. More recently a new type of record, the Grid proposed by N. C. Wetzel,¹¹ gives promise of a simplified and rational estimate of the physical progress of children, each examined in the light of his own growth.

New Nutritional Status Studies. In the last three or four years, there has also appeared a new group of criteria for nutritional status, based on specific indices of deficiencies. These include blood analyses for hemoglobin, ascorbic acid and serum protein, eye examination for signs of riboflavin and vitamin A deficiencies, X-ray tests for bone development.

Systematic use of these and other indices was adopted by the Milbank Memorial Fund study of adolescents in New York,¹² by the Pennsylvania State College group¹³ in their study of families, by a North Carolina group,¹⁴ and at present by those studying the status of workers at the

NUTRITION OF THE SCHOOL CHILD

Lockheed airplane factory in southern California.^{15,16}

More detailed information as to the dietary deficiencies of adults and children can be obtained by such means, but at much greater cost than the schools can usually pay. Some of the measurements now being made may prove to be less reliable than others, but many more detailed and long-continued observations are needed before a choice of the most significant and practicable can be established.

The ideal treatment would envisage the application of both general and specific tests to all the children in a group, supplemented by the gathering of information as to the dietary habits of the families and followed by administration of foods supplying the nutrients indicated as inadequate by the condition of the children.

Besides thus discovering children who are undernourished or malnourished, the school health officials should, and sometimes do, suggest for them to family or public health authorities not only proper dietary supplements but also medication.

The question of choice of treatment, by food alone or by food and vitamin or other special preparations, for seriously malnourished cases is one which cannot be answered by generalizations. If a child is in an obviously depleted condition it may not be wise to wait for the slow but sure building up by well-selected foods. Even in these cases provision of such food should never be omitted no matter what else may be done. Prescription of rest periods and adequate sleep, supervision of exercise and study as well as dietary concentrates and foods, all find a place in the reclamation of children who have been allowed to burn down their birthright of health.

Nutrition Education Must Not Be Neglected. The educational phases of the improvement of the nutrition of children is only now beginning to be stressed.

These must extend to parents and teachers as well as to the children if any permanent good is to be done.

The education of parents is certainly indispensable whether their children happen to be well- or ill-nourished but particularly if the family income is restricted. The expensive and careful building up of children during the school year has been only too often undone during the unsupervised vacation periods. And the help which better meals at home can give the school child can certainly not be overlooked. The important role of nutrition in pregnancy and during infant and preschool years has also been established so firmly now that it would seem superfluous to point out the advantage of nutrition education of mothers.

The means of getting mothers to listen to advice in regard to food choice are varied and none are easy. The PTA meetings offer the easiest avenue but to only a small proportion of families. Other well-known devices are home visits by the teacher or the nurse, menus, recipes, and dodgers sent home by the children, evening classes, instructions in connection with voluntary service by mothers in the lunchrooms, talks and demonstrations at all sorts of community meetings.

The need for education of teachers, nurses, and indeed the principals, superintendents, counselors, school board, and school physicians and dentists cannot be ignored. Great strides have been made in the last decade in our scientific knowledge of nutrition and in the practical and technical phases of food production. Bewildering claims are made about these matters so that the most intelligent of the laity may be uncertain as to what can actually be accomplished.

Nutrition in Nursing Education. In every modern school of public health nutrition is prominently listed among the indispensable fundamental fields. Indeed

PUBLIC HEALTH NURSING

perhaps only two great phases of public health can now be discerned, control of harmful microorganisms and provision of good nutrition. The nurse needs sound scientific instruction in nutrition, and she must have more than a textbook and diet kitchen acquaintance with the subject if she is to keep pace with the rapid progress now under way. Both laboratory and clinical experience are essential and

are now available. Besides the usual instruction in food chemistry, digestion and metabolism, the future school nurse should take part in anthropometric measurement, nutritional status determinations, dietary surveys, animal feeding experiments and supplementary child feeding work. Her judgment and enthusiasm as to needs and results of good school feeding will rarely fail her thereafter.

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Sharing the Eye Health Program with the Teachers

By ELEANOR W. MUMFORD, R.N.

TODAY more than ever public health nurses in schools are faced with a challenge for sharing the school health program with teachers. Health has long been recognized as the first objective in education. This can only be a vital factor in the educational program if teachers make it so by participating in the health work of the school to the fullest extent of their ability. The present shortage of doctors and nurses has increased the health responsibilities delegated to laymen under the supervision of medical and nursing personnel. It has been proven in various types of situations that there are many functions previously carried solely by doctors and nurses which can be efficiently performed by laymen if they are properly taught and supervised. Furthermore, laymen participating in health programs have found a great deal of satisfaction in performing these duties.

Teachers' responsibilities for certain aspects of the health program have even been written into law in some states. In several states the law stipulates that teachers must make routine tests of vision, reporting their findings to the school medical department, the public health nurse, or directly to the parents.

Despite such laws and similar regulations in some city school systems, it is not uncommon to find the public health nurse spending a large portion of her time making these tests. Why is this so?

Probably the chief reasons are attitudes of nurses, school administrators and teachers. Traditionally all routine tests, even weighing and measuring, were largely functions of the nurse. Gradually, however, as the scope of public health nursing in schools has broadened and the concept of these tests as a part of the public health education program has been realized, certain duties have been delegated to teachers. Some nurses, however, continue to like to perform these duties themselves. They say that while making routine vision tests they have an opportunity, at more or less regular intervals, to see and talk briefly with each child in the school system. However, the time consumed in giving the tests decreases that available for carefully planned conferences regarding the health needs of the child as a whole, with teachers, parents and even with children.

Teachers do not always welcome the delegation of these responsibilities to them; many feel that these are duties of the nurse and that they are being asked to take on work which is rightfully hers. Furthermore, their schedules may be crowded and they do not see how they can fit the new duties in. Teachers may also doubt their ability to make the vision tests as accurately as the nurse and many lack any preparation for this function.

School administrators may also share these attitudes. If a program of dele-

PUBLIC HEALTH NURSING

gating to the teachers the responsibility for vision tests is to be a success, superintendents, supervisors and principals must be convinced that it is desirable for the teacher to take on this responsibility. They must be assured that the teachers can learn to do it adequately; they must be willing to adjust teachers' schedules to provide time both for learning to make the tests properly and for giving the tests. Last but perhaps most important of all, they must place the nurse in a position where the teachers will recognize her as their instructor and supervisor in this function. The nurse who is accepted as a member of the faculty is fortunate indeed.

THE CHIEF arguments for teachers' giving these tests and other similar routine health tests is the fact that in this way they can become a part of the health educational program; that their daily observations of the children's behavior and appearance are likely to be sharpened by seeing them repeated in the test situation. The test, itself, then becomes a subject for a health education study. The nurse becomes a consultant to the teachers in planning this program and in carrying it through. In bringing this matter to the administrators, the conservation of the nurse's time can be stressed provided she can show him that her time can be used to better advantage in a consultant capacity.

Much resistance on the part of the teachers to accepting this duty can be avoided if the matter is taken up first through the administrators and they discuss it with teachers before the nurse does. The approach to the teachers is then one of assisting them to meet a new responsibility and to be in a better position to recognize the individual differences in their pupils. In teaching the teachers to make the tests, emphasis should be placed on observations as well as on the procedures and techniques employed.

Before initiating a program of testing by teachers, it is necessary to decide on the procedures to be used. Here the nurse needs medical guidance. It is very important that the specialists to whom these children will go for examination and treatment have confidence in the testing program. Therefore, they should have an opportunity to indicate the kind of tests they believe teachers can be taught to use satisfactorily. If there is a school physician, he may wish to take this matter up or make the decision himself. Lacking a school physician, the nurse may consult the local specialists or the sight conservation committee of the state or county medical society.

Often the recommendation will be that the teachers be taught to observe and report symptoms and to make tests of visual acuity while tests of other aspects of visual functioning remain the responsibility of the physician or of the school nurse.

CENTRAL visual acuity is the most important single aspect of vision. Without it reading would be impossible since it is through this function that form and shape can be distinguished. The universally accepted method of testing this function is the Snellen Test. The procedures used in this test are simple and can readily be taught to teachers. Each teacher should be provided with a carefully prepared outline which emphasizes such points as the exact measurement of distance the child should be from the chart during the test, the principles of lighting, the method of recording, the type of symptoms to be watched for both during the test and in the daily classroom situation.*

*Inexpensive Snellen charts, an outline covering these points and window cards for showing one letter or symbol at a time are available from the National Society for the Prevention of Blindness, 1790 Broadway, New York, N.Y.

EYE HEALTH PROGRAM

A demonstration should be given to the teachers, preferably in a group. This should be followed by supervised practice. Both for the demonstration and practice periods many nurses prefer the teachers to take turns in testing each other rather than testing children. This permits free discussion both of the performance of the tester and of the findings.

If teachers are to use other tests in addition to the Snellen, it may be desirable to start with that and gradually introduce others. In demonstrating any test, time should be taken to explain fully its value and its limitations. Every teacher should understand that these are screening procedures and not a substitute for eye examinations. It is seldom possible to attain scientifically accurate results with vision tests in a school situation. The best which can be hoped for is to find the children who have a significant degree of eye difficulty.

Careful explanation should also be made in the matter of interpreting the results of vision tests. For example teachers should know that 20/40 does not represent fifty percent of normal vision—that the Snellen fraction is merely a convenient method of recording and cannot be translated into percentage. But they should understand that it does mean that the smallest size object this person can see at twenty feet is so large that one with normal sight would see it at forty feet. However, even this needs further reservations because an expert repeating the test under ideal conditions may get a much better result—perhaps even a 20/20. Teachers should realize that attaining a normal on any screening test should never be interpreted to mean that no eye difficulty is present. Stress should be placed on the fact that test findings must always be considered in relation to their observations of visual behavior and complaints of the children.

PRECEDING the demonstration some nurses give the teachers a list of symptoms they would like them to watch for. These can be made up in a cross-chart form with a column for the children's names and separate columns for each symptom. (Such a chart can be made by condensing the list of observations in the outline of directions referred to in the footnote, page 504.) The teacher then for several days can check opposite each name any observations she makes. This provides a basis for a discussion with the individual teacher or in the group.

In demonstrating tests it is desirable to use a situation similar to that which the teachers will have to use and to show how to adjust the conditions as nearly as possible to the desired standard.

Following the demonstration and supervised practice in the teachers' groups, the nurse should observe individual teachers testing the children in actual practice. In some schools nurses recheck the children who the teachers' tests seem to indicate should be referred for an eye examination. If the nurse is confident of the teacher's ability to make the tests (under the existing conditions) it would probably be preferable for her to recheck the children whose vision seems to be only slightly below normal because as already indicated under more ideal conditions the nurse with her greater experience in testing may get a better result than the teacher. This tends to minimize referral of children unnecessarily.

There will probably always be a margin of such referrals but this should not be large. Some of these will be children whose apparent eye difficulties are due to underlying health problems. Effort should be made to discover these through correlating the vision tests with physical examination findings. If however eye symptoms persist after the correction of other physical defects a conference should

PUBLIC HEALTH NURSING

be held with the eye specialist to find out if he thinks it necessary to see the child again. If the eye defect was minor, he may have felt it was not necessary or desirable to treat this at least until the other conditions have been remedied, but he may wish to review his findings or to see the child again at a later date.

IF THE teacher's interest is to be held in her part of the eye program, she must be kept informed of the progress of the follow-up. She should be aware that glasses are not the sole method of treating eye conditions, that in some eye defects glasses may not be prescribed at all. This requires careful interpretation of the doctor's findings and recommendations. If this is done the teacher becomes a valuable ally in follow-up. She encourages the child and the parents to seek and follow expert advice. If glasses are secured, she should know what instructions were given in regard to their use in order that she may guide the child to carry out these orders. She can also teach the child to prize the glasses and take care of them. She should observe the condition of the glasses and when they get bent, scratched or broken discuss the matter with the child and if necessary with the nurse.

This is a day by day exchange of information. Such an informal method of reporting will however not be adequate for the teacher to report her vision test results to the nurse. For this a classroom report form seems to be the most satisfactory. Such a form should provide space opposite each child's name for recording the results of each test used and for each step in the test. For example, the report on visual acuity should provide space for reporting the vision in each eye

and both together with and without glasses. There should also be ample space for the teacher's comments about her observation of symptoms whether in daily classroom activities or during the test. These reports should be sent to the nurse promptly as soon as the tests of all children have been completed. Some school administrators set a date by which these must be finished.

IT SHOULD be assumed that the nurse continues to supervise the vision testing program of the teachers. With a good working relationship this should not present any problem. It should also be a continuing responsibility of the nurse to see that the teacher is provided with proper equipment and that this equipment is kept in good condition with such replacements as necessary. This is important in the use of Snellen charts which must be clean and should be kept covered when not in use.

Sharing in the vision-testing and follow-up program frequently makes the teachers more interested in other aspects of eye health. Often they become more alert to maintaining classroom conditions which are conducive to eye comfort. They may borrow the light meter from the health office and make classroom lighting surveys, teaching the children to make a better use of shades and artificial lighting. Sometimes they will recognize the advantage of rearranging furniture to minimize glare and make maximum use of the natural lighting. These are valuable by-products of interesting teachers in the eyes of their pupils through delegating to them the responsibility for routine vision tests and sharing with them the activities of the follow-up program.

A Hearing Program for the Public Health Nurse

By WARREN H. GARDNER, Ph.D.

THE PUBLIC health nurse is in a strategic position to effect the most adequate readjustment of the physically handicapped child. She assists in his discovery and is responsible for persuading the parents to obtain medical service that restores the child to normal physical efficiency or at least efficiency within limits of the handicap. Likewise, she interprets the child's physical deficiency to the teacher, who arranges a program suited to the nature and degree of the handicap. Hence, it is the duty of the public health nurse and the health department to share with school authorities in the discovery of physically handicapped children, obtain whatever medical attention is necessary so that the school may then make appropriate educational adjustment.

The physically handicapped child who has been most seriously overlooked is the hard of hearing. The nature of the defect is such that it is often not known to the child or parent and not suspected by educational and medical supervisors. The writer is acquainted with numerous children who were adjudged of low intelligence, and several who were committed to the school for the feeble-minded, who were later found to have handicapping hearing deficiencies but normal or above average intelligence. Numerous problem children have been routinely mishandled, without discovery of their hearing handicaps. One reason for this misunderstanding was failure to study the whole child.

Another one was that information on hearing deficiencies had not been generally available to the medical and educational profession. This condition has rapidly changed as modern methods of hearing conservation, detecting and treating hearing defects and retraining the hard of hearing, were developed.

The American Society for the Hard of Hearing is largely responsible for proving that hearing deficiencies in school children is one of the most important public health problems. Since its founding in 1919, it has instigated scientific investigations which produced audiometers that permit mass testing of school children. Discovery and subsequent study of these children's problems have been facilitated by utilizing the amplification derived from the radio tube. Thus, intimate study of hearing by the audiometer today is somewhat similar to the earlier use of the ophthalmoscope to observe conditions of the eye.

Testing of school children by audiometry has progressed steadily through the earnest education of school and medical officials by the American Society for the Hard of Hearing. Officially introduced in 1924, the audiometer was used to test the hearing of 180,000 children in 1928, according to a report of the chairman of the Children's Committee of the Society. In 1933, 45 cities in 22 states reported tests of 491,321 children. In 1939-1940, 780 towns and 110 counties in 36 states

and Hawaii reported tests of 3,173,079 children. Since that report, compulsory tests have been legislated in Indiana and Washington and extensive programs have been initiated in other states which have raised the total tests annually to over 4,000,000 children in over 1,000 cities.

HEARING DEFICIENCIES COMMON

Extensive testing has produced sufficient evidence to prove beyond any doubt that hearing deficiencies are present in a substantial portion of the school population. Officials who deny the presence of hearing-handicapped children in their school systems merely do not have the proper information. The most recent report of the Children's Committee showed that in 36 states 4.9 percent of the school population (unselected groups) were deficient on the basis of two group audiometer tests with failure at 9 db. The writer found in Oregon that 4.4 percent of 66,060 unselected pupils in 30 counties were deficient on the basis of failure on two group tests and a third pure tone or pitch audiometer test. These figures are consistent with those found by the writer in surveys in Iowa and Indiana.

It is consistently found that 1 percent to 1½ percent of school children have one noticeably handicapped ear. For example in Indiana the writer found 599 such children among 59,950 tested. In some communities of Oregon the incidence was over 2 percent. It is interesting to note that many of these cases were not known to the children or parents, and that in demonstrating the loss to the latter, it was found that many parents had a similar condition in one ear. Surveys by the Lip Reading Department of the National Education Association show that the percentage of total enrollment of school children who receive lip reading in individual cities was an average of 1.7 percent and a median of 1 percent. In Oregon, the criterion for special education established by the State

Department of Education is an average loss of 20 percent (25 db)* in the better ear. On this basis, 406 out of 62,641 unselected population or .6½ of 1 percent (range .003 to .01) were found under standard. This criterion is probably more rigid than that used in the cities mentioned above where the lip reading is given on the basis of need as indicated by school achievement. However, assuming that 1 percent of school children need special education, 300,000 should be receiving this service today.

Evidence that should convince the most skeptical is now available to prove that prompt medical treatment can restore hearing to normal or eliminate the cause of continuing impairment. Likewise, it is observed that neglect of hearing defects and ear conditions permits increasing and probably permanent impairment. U. S. Public Health and National Research Council reports show that:

1. out of 10,000 children, 44 every year will acquire handicapping deafness
2. 25 to 30 percent of ears that have slight losses will acquire marked losses in five years
3. 5 percent of normal ears acquire marked high tone losses and 2 percent of normal ears acquire marked loss for speech sounds in five years.

TREATMENT IMPORTANT

In Oregon, where a complete hearing conservation program is now in its fourth year under auspices of the Division of Maternal and Child Health of the Oregon State Board of Health, it has been possible to compare the results of children who went to physicians with those who did not. Among the children who went to physicians were 58 percent who improved their hearing significantly compared to 28 percent who improved but did not go to physicians. The hearing of

*Pure tone audiometer test.

34 percent remains the same who went to physicians, compared to 52 percent who did not. It is most important to note that 8 percent of those who saw physicians were worse compared to 20 percent who did not go to physicians. In other words, twice as many improved who went to physicians as those who didn't, and two and one half times as many got worse who neglected medical attention as those who received it.

The value of medical treatment of the ear is being demonstrated in scientific investigations at university hospitals such as Johns Hopkins. There it has been reported that middle ear disease, or otitis media, which is present in many deficient cases, is definitely correctible if given prompt medical treatment. It is also reported that so-called old-age or high-tone deafness begins early in the lives of school children and that certain pathologies responsible for this may be eliminated and thereby prevent further progress in many of the cases.

THE NURSE AND HEARING CONSERVATION

What can the public health nurse do to discover and assist children who have deficiencies in hearing? The American Society for the Hard of Hearing and the American Academy of Ophthalmology and Otolaryngology are agreed on the fundamental principles of hearing conservation. The following steps are necessary in order to carry on a complete program of hearing conservation.

1. Hearing tests for all children by scientific methods. The group or phonograph audiometer enables a qualified technician to test as many as 500 older children a day. Although it has definite limitations, in that it does not detect all children with hearing deficiencies, especially in the high-tone region, the phonograph audiometer will permit discovery of more children than the educational and public health staffs of large school popula-

tions can conveniently handle within a calendar year. Wherever it is suitable to the time and training of the staff, and without sacrificing mass testing, the pure tone or octave audiometer should be used in order to detect the hearing losses of children who are not ordinarily detected by the phonograph method. When the phonograph audiometer is used, the failures in the first test should be retested immediately, and later given a third, pure tone audiometer test. No referral to a physician should be made on the results of the phonograph test. However, in lieu of the pure tone test, failure in a third individual test on the phonograph audiometer, together with positive history, may be used for the basis of referral to a physician.

2. Adequate follow-up to include otological examination and treatment is imperative. In larger cities, the parents receive first information and instructions about the hearing deficiencies of their children from an otologist at a school or public health clinic. In smaller communities and rural areas, the local otologist or county health officer is asked to advise concerning the disposition of each case. Eventually all cases will receive appropriate treatment by their family otologists. It is extremely important that a retest of all deficient cases be given a year later in order to measure improvement or decline in hearing.

It is important that the public health nurse persist in the follow-up of the deficient cases. It saves time by inviting all parents of these children to school where more detailed explanation of the hearing program can be given and a greater impression is made upon the parent. Those who do not come to school will be followed up in the routine family visits.

3. School adjustment of the handicapped child is imperative in order to correct or prevent personality and achievement failures. The nurse, teacher and

PUBLIC HEALTH NURSING

principal should discuss the specific problem of each child and make arrangements to assist him in accordance with his needs. Notations and instructions should be left with the child's permanent record in order to forewarn his future teachers. Special assistance should be given according to the defect, such as special seating, lip-reading, voice and speech instruction, remedial reading or tutoring in specific subjects. Group or individual hearing aids not only ease instruction problems but, with adequate coaching, quicken development of speech and language. Let it be stated here that the belief that a hearing aid or lip reading instruction injures hearing or decreases the power to hear should be relegated to the past alongside superstition and witchcraft. Amplification of speech sounds through a hearing aid trains one to use residual hearing which otherwise would never be known to exist. And lip reading permits reading speech on the lips that is not heard by ear.

A high school student with handicapping hearing should be registered with the vocational division of the state department of education and given counsel regarding future training and occupation. Deans of boys and girls in high schools have surprisingly meager information on social, emotional and vocational problems of hard of hearing high school pupils. These students will return deep gratitude to the public health nurse who interprets their problems to the educational staff.

4. Although it is only of indirect concern to the public health nurse, it is the opinion of leading otological and hard of hearing societies that there should be full-time directors of work for the hard of hearing on the staffs of both the state department of education and the state department of health. Statewide supervision of public health problems of the hard of hearing and their social, medical and scholastic readjustments will thus be more likely to be consummated.

5. Training courses in methods of lip reading should be given in teacher training colleges. Courses in hearing conservation, including administration of hearing tests, causes of deafness, etc., should be given in public health nursing classes. Thus a complete understanding of hearing problems of children will eventually be had by all persons in the educational and public health departments.

6. Education of the public, teachers and parents is an important phase of conservation of hearing. Holding the regard of the community for health protection, the public health nurse should dramatically present the proofs of the needs and importance of prompt medical attention.

SPECIFIC NURSING OPPORTUNITIES

Some of the more specific contributions that a public health nurse should make to her community can be begun at once.

She should obtain adequate training in administration and interpretation of hearing tests. It is most important that she be familiar with standardized testing procedures.

She must pursue the follow-up of defective cases to completion of medical and beginning of educational adjustments. Hearing tests alone mean nothing unless adjustments are effected.

She can be ever alert to the possibility that a physical defect may be responsible for educational or social deviations rather than intelligence. The whole child must be studied.

She must be ever alert to the presence of hearing defects among preschool children. When making a home call, a casual remark by the parent or question by the nurse may uncover a serious case whose future may be directed into one of happiness by prompt medical attention. Much preventive work can be done before a child enters school.

On admitting a child who has been

HEARING PROGRAM

absent with earache, the nurse should ask if a physician has treated him. If not, urgent attention should be given to this matter. If the child has had a contagious disease, careful watch should be made for complications about the ear.

Hearing conservation rightly is becoming an important phase of public health supervision. Three state departments of health have employed consultants in hearing under their divisions of maternal and child health (Oregon in 1940, Michigan in 1942 and California in 1943). The medical profession is urging that more

state departments adopt this supervisory work. Medical treatment administered promptly is now definitely proved to be effective in restoring hearing of children. Conservation of hearing is successful directly in proportion to the amount of time spent on discovering and obtaining treatment of hearing defects.

The public health nurse who discovers the hard of hearing child and speeds him toward medical and educational adjustments will contribute largely to the economic welfare and emotional happiness of many future citizens.

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The School Nursing Section

By MELLIE PALMER, R.N.

THE SCHOOL Nursing Section was organized almost two decades after the origin of school nursing in 1902. It came into being because of the need for guidance expressed by an increasing number of public health nurses who were attempting to function in this field. The field was becoming increasingly complicated. In 1902 school nursing had seemed comparatively simple for it was then that the control of communicable diseases, particularly of the nuisance variety, was demanding attention. Such conditions as impetigo and pediculosis were the frequent causes of prolonged absenteeism. Assistance in obtaining diagnosis and proper treatment were functions with which the nurse was familiar and which were rather spectacularly impressive because of the quick results obtained. Then followed a period when the gross remedial defects occupied much of the attention of nurses and school physicians. These efforts, too, were impressive in the results achieved during the earlier years.

However, as time passed, and after the first World War, more and more persons became interested in school health. Emphasis was being given to health examinations and to health education, the natural and logical results of the fact-finding activities with which the nurses and physicians had been engaged earlier. New and refined techniques had to be evolved in order that the nurse's and physician's work might meet the educational criteria which were becoming recognized as essential to success. Also, it became apparent that the health program of the school was becoming an increasingly comprehensive one, made up of many phases including all those factors having to do with health service, healthful school living

and instruction in health behavior, attitudes and information. As such many persons contributed to it. Therefore careful administrative planning and coordination of activities were imperative if any degree of success was possible to achieve.

The work of the School Nursing Section reveals interests and activities which parallel this trend. During its early existence it was quite concerned with the improvement of techniques employed by the nurse in carrying out school nursing functions such as inspections of vision and hearing, inspections for signs of communicable disease, et cetera. The Education Committee of the Section was concerned with the problem of the improvement of the educational background of the school nurse. Later the emphasis seems to follow the general trend in public health in which increasing importance is given to a unified family health service and to methods of coordinating the work of the many persons interested in the health of the school child. Thus, instead of the Education Committee directing attention to increasing the educational background of the "school nurse" one sees it directing its attention toward increasing the "school nursing" content of public health nursing courses which are being used to prepare nurses for public health nursing.

For a number of years the Section has had as its secretary one of the staff of the NOPHN through whom many helpful and important developments are made possible. One of these developments which is no longer new, is the school nursing number of PUBLIC HEALTH NURSING Magazine, which appears each September. The work of the various committees of the Section is augmented

SCHOOL NURSING SECTION

and greatly facilitated by the secretary who serves as an *ex officio* member of each.

The trend which the work of the Section is taking is probably best shown by naming some of the active committees and briefly mentioning their functions. One of the most recently organized committees is the Joint Committee on Lay Participation in School Nursing composed of both lay and professional persons. Its chief objective is to develop public understanding of the work of the school nurse, and promote voluntary activities in connection with the school health program. Dorothy Nyswander is its present chairman. (See page 524.)

A new committee was organized this biennium, the Committee to Set Up Standards of Supervision for School Nurses, the name of which is descriptive of its purpose. (See page 522.) Mary Ella Chayer is the chairman.

The Committee on Camp Nursing, with Mrs. Helen Leighty as chairman, made a survey of camp nursing during the last biennium. Its functions are to bring about higher standards of nursing service for camps, devise ways of acquainting camp directors with what to expect of nursing service and where to obtain qualified public health nursing personnel for camps, and to find ways of helping camp nurses to conduct adequate nursing service at camps.

Fern Goulding is the chairman of the College Nursing Committee which has suspended for the duration the extensive survey of college nursing which it had started. This was to serve as the basis for the development of college nursing standards.

When the revised minimum qualifications for public health nurses appeared it was necessary to revise the qualifications for school nursing positions to be

certain that they were in harmony with those accepted for 1940-1945. Grace Lawrence is the chairman of this committee which has already submitted its report to the Executive Committee of the Section. Two other committees are the Committee to Revise School Health Record Forms, with Frances Titus as chairman, and the Committee to Study School Nursing Procedures, with Mary B. Hulsizer as chairman. The former has recently completed its job. (See page 521.) The latter has collected a mass of data which is now being analyzed for the purpose of a final report. The Nominating Committee for this biennium has Marie Swanson as its chairman.

As one reviews the purposes of these committees, one realizes the importance of the problems with which they deal and the extent to which they exist in many parts of the country. Yet comparatively few have the privilege of community participation in uncovering and suggesting solutions for them. It might be pointed out here that the plan being utilized by the Committee working on supervision is one which might well be emulated more often by others. This plan provides for the appointment of subcommittees in each state for the purpose of determining the extent of the problem, the need for evolving solutions and suggesting possible remedies. This method activates more public health nurses who are doing school nursing to take some responsibility for the affairs of the Section and it helps the Section to be of real assistance because it is brought into juxtaposition with front-line problems. Lastly the effectiveness of the work of the Section is dependent upon the extent to which its recommendations become realities in local communities where school nursing is being conducted.

Can the School Nurse Help Budget Doctors?

By J. LOUIS NEFF

THROUGHOUT the nation about one third of our physicians are away from home serving the armed forces. Through the efforts of the Procurement and Assignment Service, in most communities there has been a fairly successful attempt to prevent a complete stripping of medical manpower. In those areas where this was not possible, the Service is now attempting to secure replacements by the "resettlement" of physicians not needed elsewhere but there are few sections which have not lost at least a third of their doctors.

Obviously the men who are left are for the most part either too old to fight or are men who have been rejected because of physical defects. In either event they are none too well equipped, physically, to carry the full burden of "service as usual" to the civilian population. Mathematically, with one third of the doctors away, the men who stay home would have to take care of half again as much work. Practically, it does not work out just that way. Many of the latter were not fully active before the war and are not able to give full-time service now; many were not popular before the war and are not too popular even with the shortage. What really has happened is that the busy practitioner of pre-war days is now being called upon for two or three times as much service as he was before.

Except in very unusual circumstances, the hospitals are being permitted to retain

the services of interns for only one year rather than for the year and a half to two years which was standard practice before. Most of the young graduates are going into service as soon as they have finished their one year of internship. Those who are rejected for military service probably will not equal one third of the number of physicians who normally die each year. Residencies can be taken only by those who for one reason or another are not eligible for military duty. This of course puts an additional burden on the doctors of hospital staffs who are now doing much of the work formerly handled by senior interns and residents. In some hospitals these visiting staff physicians are actually taking turns going to the hospital to sleep so that any emergencies can be taken care of.

This picture of doctor shortage certainly emphasizes the fact that we cannot afford to "waste" the doctors we have left if we don't want a long war to cripple our civilian services. Too much work and too little rest will kill a doctor just the same as it will kill anyone else. Some way must be found to help the doctor budget his time and his strength, not merely to help him do a better job for the present, but also to help make certain that he will "last" through the emergency. We can't "re-cap" our doctors the way we can our tires. The present group will have to last the entire population until after the war.

BUDGETING DOCTORS

CAN THE school nurse help in this budgeting? The school nurse and her sister public health nurses can probably contribute more to this effort than anyone else in the community.

State and county medical societies throughout the nation have been attempting to educate the public on certain obvious things which can be done by the patient to help the doctor in the emergency. Many societies have prepared posters for display in doctor's offices and in public places; others have prepared statements for the doctor to mail to his patients with his bills; a few societies have bought newspaper space for display advertisements. The illustration shows a typical example of an office poster. This poster was also reproduced in small size to fit into an ordinary business envelope. The small copies were mailed to patients and put on the table in the doctor's waiting room.

THERE probably never was a greater opportunity than now for good sound health education work to produce tangible results. The public is becoming aware of the need for giving more thought to personal health. Food rationing has made people think more of nutrition; the official and voluntary agencies are redoubling their publicity on such topics as cancer, tuberculosis, the venereal infections; accident prevention is being made a part of the patriotic effort; the hospitals are known to be crowded, the doctor shortage is being recognized and people are coming to realize that it is safer to keep well than to count on too much luxury service. More than that, less and less frequently does the nurse who is doing health education work hear the excuse, "I can't afford it." Not only is unemployment limited to the unemployables, but the average worker's income is much increased. The stores are well-nigh empty of the irresistible items which once emptied the pay

envelope and mortgaged the income for months in advance; people can afford the necessities now that the luxuries are unobtainable.

The American public has paid a very high price for health neglect and for unwise health habits. The Committee on the Costs of Medical Care, back in 1932, reported that the annual expenditure for patent medicines and the services of cultists was fully 485 million dollars and commented that much of the latter and practically all of the former represented wasted money. These two items amounted to more than was spent on dentists, more than half of what was spent on hospitals and nearly half of what was spent for doctors. Here is surely a fertile field for the school nurse who wants to take advantage of the present opportunity for education.

Another bad habit of the American people is related to the patent medicine habit, and perhaps almost as expensive. Both arise out of the willingness of the patient to make his own diagnosis. If he doesn't try some worthless but expensive nostrum, or if the patent medicine doesn't do all the radio or the next door neighbor promised for it, the patient is apt to rush off to a particular specialist who he believes takes care of his supposed ailment. If, as usually happens, the patient's diagnosis is incorrect and the specialist therefore not the right one, there is loss of professional time as well as wastage of patient's money.

WITH the increase in public interest in health this is also a golden opportunity to get corrections made on those physical defects which have cropped up year after year on the same child ever since he entered kindergarten. Here unfortunately we might run up against the snag of hospital and doctor shortage. So the wise nurse will make sure of her local conditions before she starts an extensive

PUBLIC HEALTH NURSING

YOUR DOCTOR, THE WAR, and YOU.

Rationed gas, rationed tires, rationed doctors!

The Armed Forces are requiring the services of an unusually large number of Nassau County doctors. Those left will have greatly increased burdens.

How can you and your family get the most from the limited medical service that will be available?

- 1 — Instead of asking the doctor to come to your home, go to his office when you can. This saves the doctor's limited time—and incidentally saves your money.
- 2 — If a house visit is necessary, call the doctor early in the morning so he can plan his house calls efficiently.
- 3 — Don't neglect the early signs of sickness. A timely visit to your doctor may prevent serious illness, numerous house calls, and eventual hospitalization. Hospital beds are scarce. Save them for patients needing surgical treatment.
- 4 — You know that early cancer and early tuberculosis are curable. You know that pneumonia, diabetes, the venereal infections can be brought under control by early medical care. Put your knowledge to action.
- 5 — Protect yourself, your children, and the workers in our vital war industries against the ravages and waste resulting from epidemics of communicable diseases. Vaccination and immunization make the presence of a single case of smallpox or diphtheria an inexcusable obstruction to our total war effort.
- 6 — Be patient with your doctor if you have to wait in his office or if he does not respond at once to your call. Remember that he is trying to care for nearly twice as many patients as before.
- 7 — Remember that the doctor only has 24 hours in his day. He must sleep and he must eat. Help him protect his own health so he can take care of yours.

Take these suggestions to heart NOW. Let us not look back a year from today and wish we had done these things TODAY!

NASSAU COUNTY MEDICAL SOCIETY

The doctor is instructed to post this notice prominently in his waiting room

program of trying to catch up on what has already been neglected. But certainly the nurse would be on productive ground if she concentrated on teaching people the importance of getting after illness and minor defects as soon as discovered.

In the publicity we read of official health agencies or private organizations, there is one phrase which constantly recurs: *early diagnosis and prompt treatment are essential*. Cancer, tuberculosis, diabetes, heart disease, polio, pneumonia—all call for early diagnosis and prompt treatment. The control of contagion in the school means early diagnosis; the control of the venereal infections requires

early diagnosis; effective treatment of mental and nervous diseases demands the same thing—early diagnosis and prompt treatment. Yet the American public continues to spend a huge slice of its medical dollar on the treatment of undiagnosed or self-diagnosed disease, and by so doing also adds to its medical bill, and its mortality record. This is the cost of going to legitimate and appropriate medical facilities either too late for prompt cure or too late for any cure at all.

The war situation and its resulting shortages might be giving the health educator a new tool with which to work. Progress has been slow by our older methods, but now we might start talking about early diagnosis because the early treatment of disease takes less of the doctor's time and might prevent hospitalization. If we can convince people that they should go to their doctor while they can still get to him, rather than waiting until he has to come to them; if we can make them understand that gambling at the race track is not as dangerous as gambling with their own lives; if we can show them that it is safer to consult a physician about a minor illness than to wait until they need a hospital bed which is not available and a doctor who is too busy to come to their homes, we would not only be helping the program to make our medical facilities "go around" in the emergency and the plan to "budget our doctors," but also we would be making real progress along the road of health education.

New School Year: Challenge and Answer

(Continued from page 481)

approved techniques for doing so studied.

With the quickening tempo of the entire school staff to educate for victory, we must re-define our present duties, in order that those which are essential will be better

performed and others assumed if they are necessary. As we start the new school year with our greatest challenge of all times, let us direct our plans to the end that fitness will be constant and lasting for the beginner on the threshold and achieved for passing youth before it is too late.

—B. B. R.

At Fourteen—Questions Galore

By ALLENE A. BIRK, R.N., RUTH BISHOP, R.N., JULIANA MACK, R.N.,
and ETHEL RYCKMAN, R.N.

IN 1940, the superintendent of one of the leading high schools in Hillsdale County, Michigan, sent a request to the health department asking if a public health nurse might talk to pupils in the home economics classes about personal hygiene. These classes included not only cooking and sewing, but also home-making. The girls had questions, dozens of them, many of which the teacher felt she could not answer adequately. The request was granted and the classes proved to be very popular. The following year the school requested the nurse to give a little more time to the classes. The freshmen class in human relations had asked for a talk on boy-girl relations, submitting a long list of questions which they wished to have answered.

In the Fall of 1942, another high school superintendent, in a conference with the school nurse said, "These girls need to know so much more than they are taught in school. What are we going to do about it?" The answer was a course of five classes at his school—one each week for five weeks. Through a local Michigan Education Association meeting other superintendents learned of the plan, and enthusiasm for it spread like a wave so that now it is in effect all over the county.

This year the boys were not entirely forgotten. A young doctor who was in the county studying public health in a rural community conducted two and sometimes three 1-hour discussions for the boys in each high school. Students, faculty and parents alike appreciated his excellent work.

Let us see what Sue, one of our high school girls, wrote in her diary about the classes.

Dear Diary:

March 17, 1943

Gosh! It was blustery and cold today. I wish Spring would come with a bang.

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Dear Diary:

March 24, 1943

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PUBLIC HEALTH NURSING

YOUR DOCTOR, THE WAR, and YOU.

Rationed gas, rationed time, rationed doctors!

The Armed Forces are requiring the services of an unusually large number of Nassau County doctors. Those left will have greatly increased burdens.

How can you and your family get the most from the limited medical service that will be available?

- 1 — Instead of asking the doctor to come to your home, go to his office when you can. This saves the doctor's limited time—and incidentally saves your money.
- 2 — If a house visit is necessary, call the doctor early in the morning so he can plan his house calls efficiently.
- 3 — Don't neglect the early signs of sickness. A timely visit to your doctor may prevent serious illness, numerous house calls, and eventual hospitalization. Hospital beds are scarce. Save them for patients needing surgical treatment.
- 4 — You know that early cancer and early tuberculosis are curable. You know that pneumonia, diabetes, the venereal infections can be brought under control by early medical care. Put your knowledge to action.
- 5 — Protect yourself, your children, and the workers in our vital war industries against the ravages and waste resulting from epidemics of communicable diseases. Vaccination and immunization make the presence of a single case of smallpox or diphtheria an inexcusable obstruction to our total war effort.
- 6 — Be patient with your doctor if you have to wait in his office or if he does not respond at once to your call. Remember that he is trying to care for nearly twice as many patients as before.
- 7 — Remember that the doctor only has 24 hours in his day. He must sleep and he must eat. Help him protect his own health so he can take care of yours.

Take these suggestions to heart NOW! Let us not look back a year from today and wish we had done these things TODAY!

NASSAU COUNTY MEDICAL SOCIETY

The doctor is instructed to post this notice prominently in his waiting room

program of trying to catch up on what has already been neglected. But certainly the nurse would be on productive ground if she concentrated on teaching people the importance of getting after illness and minor defects as soon as discovered.

In the publicity we read of official health agencies or private organizations, there is one phrase which constantly recurs: *early diagnosis and prompt treatment are essential*. Cancer, tuberculosis, diabetes, heart disease, polio, pneumonia—all call for early diagnosis and prompt treatment. The control of contagion in the school means early diagnosis; the control of the venereal infections requires

early diagnosis; effective treatment of mental and nervous diseases demands the same thing—early diagnosis and prompt treatment. Yet the American public continues to spend a huge slice of its medical dollar on the treatment of undiagnosed or self-diagnosed disease, and by so doing also adds to its medical bill, and its mortality record. This is the cost of going to legitimate and appropriate medical facilities either too late for prompt cure or too late for any cure at all.

The war situation and its resulting shortages might be giving the health educator a new tool with which to work. Progress has been slow by our older methods, but now we might start talking about early diagnosis because the early treatment of disease takes less of the doctor's time and might prevent hospitalization. If we can convince people that they should go to their doctor while they can still get to him, rather than waiting until he has to come to them; if we can make them understand that gambling at the race track is not as dangerous as gambling with their own lives; if we can show them that it is safer to consult a physician about a minor illness than to wait until they need a hospital bed which is not available and a doctor who is too busy to come to their homes, we would not only be helping the program to make our medical facilities "go around" in the emergency and the plan to "budget our doctors," but also we would be making real progress along the road of health education.

New School Year: Challenge and Answer

(Continued from page 481)

approved techniques for doing so studied.

With the quickening tempo of the entire school staff to educate for victory, we must re-define our present duties, in order that those which are essential will be better

performed and others assumed if they are necessary. As we start the new school year with our greatest challenge of all times, let us direct our plans to the end that fitness will be constant and lasting for the beginner on the threshold and achieved for passing youth before it is too late.

—B. B. R.

At Fourteen—Questions Galore

By ALLENE A. BIRK, R.N., RUTH BISHOP, R.N., JULIANA MACK, R.N.,
and ETHEL RYCKMAN, R.N.

IN 1940, the superintendent of one of the leading high schools in Hillsdale County, Michigan, sent a request to the health department asking if a public health nurse might talk to pupils in the home economics classes about personal hygiene. These classes included not only cooking and sewing, but also home-making. The girls had questions, dozens of them, many of which the teacher felt she could not answer adequately. The request was granted and the classes proved to be very popular. The following year the school requested the nurse to give a little more time to the classes. The freshmen class in human relations had asked for a talk on boy-girl relations, submitting a long list of questions which they wished to have answered.

In the Fall of 1942, another high school superintendent, in a conference with the school nurse said, "These girls need to know so much more than they are taught in school. What are we going to do about it?" The answer was a course of five classes at his school—one each week for five weeks. Through a local Michigan Education Association meeting other superintendents learned of the plan, and enthusiasm for it spread like a wave so that now it is in effect all over the county.

This year the boys were not entirely forgotten. A young doctor who was in the county studying public health in a rural community conducted two and sometimes three 1-hour discussions for the boys in each high school. Students, faculty and parents alike appreciated his excellent work.

Let us see what Sue, one of our high school girls, wrote in her diary about the classes.

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PUBLIC HEALTH NURSING

with the naked eye. Just think of it, from only two cells, even though millions and millions of cells are formed to build a human body! The first two cells are called parent cells, one from the mother and one from the father. That's why heredity plays such an important part in our personality, character and behavior. And, even though the mother carries the baby for nine months in her body where it grows, the father is responsible for the sex of the baby. Isn't that interesting?

Birth must be wonderful! Sue

Dear Diary: March 31, 1943

What is so gorgeous as a day in Spring? I know—a baby!

Miss Haines brought Betsy, a doll from the Health Department, with her today. She gave us a fascinating talk on the Care of the Baby Before and After Birth. It was so real I kept expecting Betsy to cry or make baby noises.

I had never thought of a baby as being nine months old before it is born. A mother takes care of her baby by taking good care of herself. Doctors must be grand people, and they certainly know a lot about us.

I'll tell you a secret, Diary. I want six babies when I have a home of my own, three boys and three girls. Sue

Dear Diary: April 7, 1943

Mother and I had a very serious talk today about the class on the subject of syphilis and gonorrhea. Miss Haines showed two films, "With These Weapons" and "Health Is a Victory," which the Michigan State Health Department loaned to us. We agreed that knowing the facts certainly can remove the fears people have about these diseases. When I have my next medical examination, I'm going to ask Dr. Smith to do a Kahn test! Eight

o'clock and I must study for an examination. Good night, Diary. Sue

Dear Diary: April 14, 1943

Today we had the last class on Social Living. It was very informal—not a lecture at all—just questions and answers on Boy and Girl Relationships.

I certainly have enjoyed Miss Haines. She taught me a new vocabulary and I am more at ease when discussing these things with Mother.

Boys and girls certainly do have growing-up problems which they often have to settle themselves. I appreciate the school's having arranged such classes for us. Sue

Yes, Sue, you were glad that these classes were included in your studies. We knew you appreciated them because of your close attention and your intelligent questions. When you said, "At last we've got what we wanted," we knew that a long-time need had been fulfilled.

Your teachers also were glad that a step had been taken in meeting these everyday problems. They realized that a problem properly handled is not dynamite but a "dynamo under control" phase of living. Your teachers had vision when they expressed the wish that parents might be given a similar series of lectures. So did the other community leaders—parents, ministers and other co-workers—who not only expressed their approval of these efforts but helped in planning the courses. With their backing this beginning in education will grow from year to year.

THE AMERICAN JOURNAL OF NURSING FOR SEPTEMBER

Epidemic Keratoconjunctivitis, Joseph G. Molner, M.D., and Laura E. Peck, R.N.

Wartime Adjustments in Obstetrics, Josephine M. Hoover, R.N.

Report of the 1943 National Survey of Registered Nurses

Michigan's Community Health Service Project, Alyce Rooney, R.N., Genevieve R. Soller, R.N., and Russell West

Nursing in the Midwestern Flood, Rebecca M. Pond, R.N.

Corrective Physical Education, Bernice Fash and Harriet Skemp-Nystrom, M.D.

Postgraduate Education Provided by Bolton Act, Eugenia K. Spalding, R.N.

The National Nursing Council, Elvira M. Wickenden, R.N.

Communicable Disease Nursing—A Cooperative Venture

By MARGARET G. ARNSTEIN, R.N.

WASTE OF materials and waste of time are both admittedly costly and undesirable and we all wish to prevent them as far as possible no matter where they occur. In public health one of the commonest forms of waste is duplication of services and the communicable disease service in many places is one of the worst offenders in this regard. Since the war began the need for economizing the time of all nursing personnel has been reiterated so often that we are rather tired of hearing it and even feel a little impatient perhaps at each new admonition to eliminate overlapping of services. We are all willing to do so but when we begin to discuss actual instances, frequently we find that each one of us thinks the *other* one should do the eliminating and as a result we continue just as we always have. There are, of course, many notable exceptions to this, where marked changes have been made to effect more closely coordinated services.

In many communities where there are three agencies, health department, visiting nurse association and board of education, nurses from all these agencies visit communicable disease cases. The school nurse visits an absentee and finds he has a communicable disease or a suspected communicable disease, let us say scarlet fever. She gives certain initial instructions regarding isolation and care, then she calls the health department to report the sus-

pected case. The health department has the responsibility of visiting all cases of communicable disease, so a nurse goes out post-haste and enlarges upon the isolation and quarantine instructions. Perhaps she finds that the patient needs nursing care but the health department does not give the service so she calls the visiting nurse association.

In this imaginary instance what procedures could be eliminated? If the health department has recognized the well proven fact that isolation and quarantine are not very effective means of control of respiratory spread of communicable disease, and have reduced restrictions to fit with these facts, there is not very much to teach the family about this aspect of communicable disease control. Under these circumstances the few simple, current regulations and procedures can easily be learned by any public health nurse in the community. Probably the school nurse already knows them and in the imaginary scarlet fever case did an adequate teaching job. However, since it is not her responsibility, she may not have taken the time to make her instructions understood. If the health department had deputized school (and visiting nurse association) nurses to give the necessary isolation and quarantine instructions, the visit of a health department nurse could have been eliminated in this instance. Such a procedure is dependent upon the willing-

ness of school nurses to assume this responsibility, acting as deputies of the health department. In the past there has been hesitancy in doing this.

In order to work out this plan the health department would be responsible for collecting data indicating needed changes, keeping other groups informed of changes in regulations and instructing them in the interpretation and application of these new regulations. Joint meetings to discuss local communicable disease problems and policies could be held periodically. School and visiting nurse association nurses as well as the health department would then consider it their responsibility to attend conferences on communicable diseases and keep up to date in their reading on this subject.

A system of reporting would have to be worked out so that the health department would know which cases the school nurse had visited and in turn the school nurse would be informed by the health department of any communicable disease cases in families in which there were school children. If a family visited by the school nurse needed a second visit the school nurse would so inform the health department who might make this second visit. Such details and many others could be worked out in conference.

The duplication of service described above could be eliminated by each agency's making changes in its policies in respect to responsibilities given and accepted. If in the scarlet fever case we are following, the child was uncomfortable when the school nurse first visited, she could give necessary bedside care and such a demonstration might be sufficient to teach the mother. If further care were needed then the visiting nurse association would be called. Exactly the same thing would apply if the health department made the first visit. If the visiting nurse association nurse made the first visit and had been deputized by the health depart-

ment to give the official isolation and quarantine instructions only one nurse would then visit the case.

To carry the idea a step further, the school nurse would consider it her responsibility to get preschool children in her families immunized—many are already doing this. If she were visiting a school child with measles and found preschool children in the family, she could give careful instructions regarding the danger of measles for the younger age group and the nursing measures to be taken if they should contract the disease. The case could then be referred to the health department for visiting at a later date when the young child would likely have come down with the disease.

Within the school itself teachers and principals are concerned with the communicable disease problem as much if not more than nurses. Teachers are usually the first to note that a child is not feeling well and should recognize signs of illness. Nurses are not diagnosticians and cannot do much more than the teacher, that is, note that the child is ill and send him home for medical care. The school nurse can do much to assist the teacher to recognize these signs and give her assurance in her ability so that she does not have to call the nurse to inspect the classroom each time a case of communicable disease occurs.

School nurses with the help of school physicians can bring principals and teachers up to date on present facts and theories regarding communicable diseases—which diseases can be controlled and how, and which cannot yet be controlled and why we cannot prevent their spread.*

*Arnstein, Margaret G. "Communicable Disease in Wartime." *PUBLIC HEALTH NURSING*, April 1943, p. 194.

Linde, Joseph I. "Emergency Public Health Nursing in Communicable Diseases." *PUBLIC HEALTH NURSING*, April 1943, p. 197.

Knowledge helps to allay fears and if the school administrators understand the known facts about the spread of the communicable diseases and realize how much about them is still unknown, they will not require the school nurse to do needless tasks. For the same reasons it is helpful to discuss communicable disease control with parent-teacher association groups

quite frequently, especially when an increased incidence of one of the communicable diseases occurs or is expected. The school, with the health department, can be a leader in community education regarding health matters. As the nurse is often the only full-time health worker in the school, it is her responsibility to help it assume this position.

NEW DAILY-MONTHLY REPORT FOR SCHOOL NURSING

A daily-monthly report form for school health services has been produced by the Committee to Revise School Health Record Forms of the School Nursing Section of the National Organization for Public Health Nursing. Frances Titus, assistant director of the Public Health Nursing Service of Nassau (New York) County Health Department, is now chairman of this Committee.

The new form was discussed with the NOPHN Records Committee, and with their approval and that of the Executive Committee of the School Nursing Section, the form will be sold by Mead and Wheeler, 1022 South Wabash Avenue, Chicago, Illinois, as are other NOPHN record forms. The price is \$2.65 per 100. A free sample and instruction sheet will be sent upon request.

This daily-monthly report is a 4-page affair. Part I, pages 1 and 2, allows for daily entries about number of pupils given health services, number for whom school program was adjusted, number of nurses' conferences, and other data. Accurate daily entries make possible an accurate monthly figure, and space for the monthly total is allowed at the foot of each column. Such figures are frequently called for by state education departments and school superintendents. It is to meet these needs that the statistical Part I is included.

Part II, pages 3 and 4, contains six sections for narrative material about classroom teaching, meetings, environmental surveys, school health committee, health literature, and problems and plans.

The 1943 daily-monthly report compromises between the needs of those recently entering school nursing and those who have been active in this field for many years. It has been under consideration for four years. It was tried out in nine places and suggestions from these trials were incorporated in the present form. It may be used by the nurse doing school work as part of a generalized program and by the specialized school nurse.

Those most interested believe it is the best that can be offered at the present time to show quality and scope of school nursing. Improvements in school nursing itself and in what needs to be reported about school health activities will change the content of the monthly report.

The headings of the 11 sections are shown below. For Sections I to V sufficient lines are allowed to enter statistics for each school day for a month. For Sections VI to XI sufficient lines are allowed to describe the activity indicated. Instructions accompanying the form explain further what the Committee hoped would be included.

I. Number of pupils given health serv-

PUBLIC HEALTH NURSING

ices—health inventory, health inspection, vision test, hearing test (individual and group), weight and height

II. Number of pupils who received professional attention—for eyes, teeth, other

III. Number of pupils for whom program was adjusted—because of sight, hearing, heart, other reasons

IV. Number of pupils recommended for—exclusion, readmission

V. Number of nurse's conferences held with—teachers, pupils, parents, others

VI. Classroom teaching or demonstration

VII. Meetings attended

VIII. How many environmental surveys have been made this month

IX. List by name and position persons attending meetings of school health committee this month, purpose and result of meeting

X. What new literature has been added to your health library this month? What literature was recommended by nurse for use of teacher this month?

XI. Narrative. Include accomplishments, needs, plans, problems, questions, other significant data

MISS EDNA L. FOLEY

Miss Foley, president of the National Organization for Public Health Nursing in 1920 and 1921, died at her home in New York City on August 4. From 1912 to 1937 she was superintendent of The Visiting Nurse Association of Chicago, Illinois. Her influence on the development of public health nursing, especially in the Middlewest, was profound and lasting. One of the pioneers in this field, the Chicago VNA under her guidance became a Mecca for public health nurses and board members from a wide area seeking help in building and rebuilding their own agencies. In 1934 she received the Citizen's Fellowship conferred by the Chicago Institute of Medicine in recognition of her service in improving civic, social and health conditions in Chicago. Indeed the sphere of her activities extended overseas as she was sent to Italy after the first World War to direct anti-tuberculosis work.

Miss Foley's deep and genuine concern for persons in trouble, her unstinted expenditure of time and effort to help them, and her stalwart struggle to bring about social improvements were recognized and respected throughout Chicago and wherever her associates went. Her circle of friends included the lowly washerwoman and some of Chicago's mightiest figures. No one but Edna Foley herself knew the number she had befriended.

Fearing that the professional approach might tend to dry up the milk of human kindness, Miss Foley might sometimes have been over-cautious in adopting newer educational methods.

She had an abiding interest in the subsequent careers of Chicago visiting nurses and was always ready to back them up with advice and encouragement. Her going will be a great loss to a host of former staff workers and other friends.

—ELIZABETH G. FOX, R.N.

Committee to Set Up Standards of Supervision for School Nurses

PURPOSE AND NEED OF STUDY

At the 1942 biennial meeting in Chicago, the School Nursing Section of the National Organization for Public Health Nursing authorized a committee to be appointed whose purpose was "to set up standards of supervision for school nurses." The reasons for such a study were indicated as four-fold:

1. That the majority of school nurses work with no nurse supervision
2. That school nurses employed by boards of education are often under the supervision of a non-nurse supervisor
3. That many school nurses are in small school systems in which the nurse works alone
4. That school administrators are unaware of what they may expect of a nurse

It was thought that this committee could study these problems of supervision and work out a set of standards. After this, ways might be determined of reaching school and public health administrators as well as nurses, in order that there would be mutual understanding of the need for supervision of the nurse in schools.

PRELIMINARY STEPS

In January 1943, Mary Ella Chayer, assistant professor of nursing education at Teachers College, Columbia University, accepted the chairmanship of this committee and the following committee members were approved: Lula P. Dilworth, associate in health and safety education, State Department of Public Instruction, Trenton, New Jersey; Marie Swanson, supervisor of school nursing, State Edu-

cation Department, Albany, New York; and Bosse B. Randle, secretary of the School Nursing Section of the NOPHN, *ex officio*.

The committee held its first meeting in February and decided that before standards of supervision could be set up which would serve all sections of the country, it would be necessary to know a great deal more about the present status of supervision, the ways in which various communities have analyzed their own situation with respect to supervision, and the specific problems which were encountered in providing supervision by various types of agencies in all parts of the country. Accordingly it was decided to appoint a committee in each state whose purpose would be to study the problems of supervision in their own state and then to share their experiences with nurses from other states.

One of the first principles which was enunciated by the central committee was that each state committee should seek a sponsoring agency. This sponsoring agency could be the State Organization for Public Health Nursing, the Section on Public Health Nursing of the State Nurses' Association, or some school nursing organization, or a combination of any of these. Splendid response has come from these sponsoring agencies, who have offered excellent leadership to the local committees.

One of the most difficult problems with which the central committee had to struggle was the persistent idea that we were studying supervision of specialized school nurses only, in spite of the fact that we specifically stated that we wanted

PUBLIC HEALTH NURSING

our study to represent any and all agencies offering any type of school nursing, full-time or part-time, generalized or specialized, in public, private, or parochial schools, under boards of education, boards of health or other agencies, and in rural or urban areas. This broad scope of our problem is gradually being accepted.

Nurses in 40 states have accepted state chairmanship and have been given suggestions for selecting the members of the committees in their states.

STUDY GETS UNDER WAY

In May 1943, letters were sent to the chairmen of the 40 state committees suggesting that the following data be secured if not already available in the office of their state director of public health nursing:

1. A list of all nurses doing specialized school nursing in public, private and parochial schools
2. A list of all nurses including school nursing in their generalized program
3. A list of all special school nursing supervisors under boards of education and boards of health
4. A list of all generalized supervisors who offer supervision to nurses working in schools
5. A list of superintendents of all state, county and local schools
6. A list of all heads of teachers colleges and nursing directors of all universities or colleges offering courses in public health nursing
7. Certification requirements for school nurses under boards of education
8. Certification requirements for generalized nurses serving the schools

To date 19 states have returned some

data and returns from this questionnaire are still coming in.

WHAT THE STUDY SHOWS SO FAR

Some of the states participating in the study had valuable data in the state office concerning the conditions under which nurses are working. They were also well aware of the areas in which supervision is available and areas in which supervision is inadequate or lacking. Some of the states, however, had to begin at the beginning and collect the most elementary data on the number, location and status of employment of nurses working in schools.

One of the most important results of the study thus far is, therefore, that over 200 nurses scattered over forty states are beginning to recognize the problems of supervision in their state and their need for help in analyzing their own problems. These committee members are, in turn, interesting other nurses to become articulate about their needs for supervision.

FUTURE PLANS

In the Fall, when more material has been received from the state committees, the central committee plans to develop a manual of supervision which will be submitted, section by section, to state committees for suggestions. The principles and policies finally agreed upon will then stand the test of a wide variety of situations. Upon completion, the manual will be distributed and interpreted to nurses, to school administrators, and to public health administrators.

—MARY ELLA CHAYER, R.N., CHAIRMAN

APPROVED PROGRAM OF STUDY

THE PROGRAM of study in public health nursing at Incarnate Word College, San Antonio, Texas, which was inaugurated in September 1942, has been approved recently by the NOPHN Committee on Accreditation. A. Marcella Fay is the director.

This brings the total number of approved programs to 30, the following 3 having been discontinued this year: University of Hawaii, University of Wisconsin, and Richmond Professional Institute of the College of William and Mary.

Joint Committee on Lay Participation In School Nursing

ONE OF THE objectives of the Joint Committee on Lay Participation in School Nursing* of the School Nursing and Board and Committee Members Sections of the NOPHN during the year 1941-1942 was to stimulate citizen interest and participation in the work performed by the public health nurse in the school. The standards for selecting school nurses and supervisory personnel, information about the type of work which a school nurse should be doing in view of increased emphasis during past years on a health program to meet the health needs of a total community rather than those of particular segments of the population—these problems needed interpretation to school administrators, boards of education, and influential citizens.

Working toward this end the Committee prepared and distributed some fifteen thousand copies of a pamphlet bearing the

title, "The Nurse in the School Health Service."

During the year 1942-1943 urban and rural areas began to face the depletion of professional health staff brought about by the war effort. The situation was immediately reflected in the dual tasks that the Committee has set for itself during this period. It is now of prime importance to see that no diminution of worthwhile health services to children of school age is tolerated. At the same time, the Committee feels the obligation to present to schools and citizens alike a health program which will provide these services through (1) conserving the time of the school nurse for the important tasks which she is best able to do and (2) delegating responsibility for accomplishing other tasks to teachers, other professional workers, and trained volunteers.

The Committee held meetings on May

*The Committee includes as members: Chairman, Dorothy B. Nyswander, regional supervisor (Region I), War Public Service, Federal Works Agency; Lula P. Dilworth, R.N., associate in health and safety instruction, Department of Public Instruction, N.J.; Mrs. William A. Hastings, president, National Congress of Parents and Teachers; Emilie W. Jean, R.N., Washington Irving Schools, Tarrytown, N.Y.; Dr. Earl E. Kleinschmidt, health officer, Toledo, Ohio; G. Robert Koopman, State Department of Public Instruction, Michigan (now in military service); Mildred C. Lant, R.N., superintendent of nurses, Bureau of Nursing, New York City; Dr. Joseph I. Linde, health officer, New Haven, Conn.; Onsville J. Moulton, supervising principal, Neptune Township, Ocean Grove, N.J.; Dr. Jay Nash, chairman, Department of Physical Education and Health, New York Uni-

versity; Dr. N. P. Neilson, executive secretary, American Association for Health, Physical Education and Recreation; Mrs. Hyman Schroeder, director of volunteers, New York City Department of Health; Mrs. David Stevens, Board of Education, Montclair, N.J.; Rep. Jane H. Todd, Assembly Chamber, Albany, N.Y.; Julius E. Warren, superintendent of schools, Newton, Mass.; Dr. George M. Wheatley, assistant medical director, Metropolitan Life Insurance Company; Dr. Charles C. Wilson, professor of health and physical education and consulting pediatrician, Teachers College, Columbia University; Mrs. Roger Young (Executive Committee, Board and Committee Members Section, NOPHN), New Jersey; secretary, Bosse B. Randle; *ex officio*, Ruth Houlton, Hortense Hilbert, Mollie Palmer, Mrs. S. Emlen Stokes, Mrs. Edith Wensley.

PUBLIC HEALTH NURSING

14 and July 23, 1943. The members have worked on the wartime aspects of nursing service in the school from the point of view "What shall be told" and "How shall it be told?" The results so far include the promotion of a statement on minimum essentials in school nursing services during wartime. The committee plans to translate this statement into suitable articles for journals reaching school and lay people.

A comprehensive enterprise is now under way which, it is hoped, will yield a consensus of opinion from widely varying groups as to the way in which many functions usually assumed by the school nurse can be performed by others without

losing the values which present health programs offer. A detailed job analysis of school nursing tasks is being made. This will form a basis of a check list to be submitted to representatives of many professional groups having an interest and share in the school health program. On the basis of the data, the Committee believes that an approach can be made toward solving some of the problems faced by the nurse who knows what she should be doing but is handicapped through lack of understanding of the relative importance of her tasks by school administrators and lay boards.

—DOROTHY B. NYSWANDER, Ph.D.
CHAIRMAN

NURSE PLACEMENT SERVICE

N. P. S. announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom consent to publish these has been secured in each case from both nurse and employer.

PLACEMENTS

- *Frona A. Yeager, nursing field consultant, American Red Cross, St. Louis, Mo.
- Marguerite Jane Glenn, clinic nurse of Louis E. Schmidt Clinic of Montgomery Ward Clinic of Northwestern University, Chicago, Ill.
- Gertrude Bradley, industrial nurse, Ready-Foods Canning Corporation, Chicago, Ill.
- Mrs. Madeline G. Dryden, industrial nurse, Industrial Metal Fabricator, Inc., Chicago, Ill.
- Mrs. Zelfha Peasley Plain, industrial nurse, Maremount Automotive Products, Inc., Chicago, Ill.

- Mrs. Mary D. Baker, camp nurse, Camp Eagle Crest, Eagle River, Wis.
- Susan Connelly, camp nurse, Camp Ohiyesa, Clyde, Mich.
- Mrs. Eda M. Muzzarelli, camp nurse, Y.M.C.A. Camp, Fremont, Mich.
- Nancy A. Tardi, camp nurse, Camp Rogers Park, Lake Villa, Ill.

ASSISTED PLACEMENTS

- Mrs. Pearl Coulter, associate professor of public health nursing and associate director of University of Colorado School of Nursing, University of Colorado, Boulder, Colo.
- *Aline F. LeMat, field director—Department of Nursing, Community Service Society, New York, N.Y.
- *Eleanor D. Maguire, staff nurse, Calhoun County Health Department, Marshall, Mich.

*The NOPHN files show that this nurse is a 1943 member.

Reviews and Book Notes

PRACTICAL SOCIOLOGY AND SOCIAL PROBLEMS

By Helen C. Manzer, Ph.D., R.N. 366 pp., J. P. Lippincott Company, Philadelphia, 1942. \$3.25.

As a supplement to a more intensive and inclusive study of sociology, this book used possibly as a handbook, should prove particularly helpful and thought-provoking to the student nurse who is a high school graduate.

Also to the public health nurse who has not had any special preparation for this particular field—and who is now frequently called the “Emergency War Nurse”—it should be of real practical assistance. It should help to orient this new public health nurse to some of the manifold and recondite family problems including, of course, health. In addition, it should give her a working concept of the inter-relationship of these problems, plus a desire for further study of matters so complex.

On the page opposite the beginning of each chapter there is a concise synopsis of what is to be discussed. At the end of each chapter there are “suggestions and questions for further study.” Inclusive up-to-date references follow each chapter.

There is a complete index; the type is easy to read; attractive pictures add interest.

MARGARET TAYLOR, R.N.
Dallas, Texas

LEADERSHIP AT WORK

Fiftieth Yearbook. 248 pp. The Department of Supervisors and Directors of Instruction of the National Education Association, Washington, D. C., 1943. \$2.

This yearbook is an original presentation of the findings of a committee of ten chosen to study school systems of the country for evidence of instructional

leadership, the purpose being to set forth ways in which such leadership is achieved.

The book is within itself a fine example of democratic leadership at work among its producers. The material gathered from all parts of the country is clearly and graphically presented, supporting the theory that the best leadership comes out of a contributive pattern, namely one which provides opportunities for individual participation in cooperative planning for the solution of real problems. One is provided a quick look-see at leadership in the making from the first mythical illustration of Centerville, the average run-of-the-mill school system, through some forty real communities.

Although the content material is drawn from the school field the principles demonstrated are applicable to many fields. It should be of particular interest to those in the field of public health because of its many illustrations of community cooperation.

B. B. R.

KEEP THEM HUMAN

By C. Madeleine Dixon. 156 pp. The John Day Company, New York, 1942. \$1.50.

Written, as it seems to have been, for the special help of auxiliary workers, it occurs to this reviewer that there is an over-simplification of the story of adequate guidance for the young child.

The author cautions the caretaker to look, listen, and take in, without sufficiently emphasizing the need for looking with eyes that have been trained to see or listening with ears that actually hear what is said and the ability to take in what happens on the level of a pre-school child.

Some of the detailed instructions in some instances should be helpful to the person otherwise unprepared to deal with the preschool child, and the chapter on "Play Is Like This" will be especially interesting and helpful.

One has the feeling that the author in trying to get away from rigidity in the handling of children has made their care sound altogether too easy.

SARA B. PLACE, R.N.
Chicago, Ill.

RECENT PUBLICATIONS AND CURRENT PERIODICALS

SCHOOL HEALTH

FOUR ARTICLES FROM *The Journal of School Health*, 3335 Main Street, Buffalo, New York. 25c.

"Health in High Schools." Gerwin Neber. April 1943, p. 95.

"Rules Governing the Physical Examination of All Girls Participating in Girls' Athletic Association and Physical Education Activities and the Examination of Girls for Referral to Special Classes." April 1943, p. 83.

"Testing Techniques and Procedures Developed for the Massachusetts Study of Health in Senior High Schools." Warren H. Southworth. December 1942, p. 311.

"What the Superintendent Should Expect from the School Health Service." John L. Bracken. November 1942, p. 281.

Here a superintendent of schools has courageously defined the health of the school child as a joint responsibility to be shared by the parent, the school and the community. He states that from the age of five years to graduation from high school, the child spends only 12 percent of his time in the public schools and that the school of the public fills up the other 88 percent. He challenges the school to be concerned about the 88 percent.

"TILL THE DOCTOR COMES MARCHING HOME: A Health Symposium." *National Parent Teacher*, 600 South Michigan Boulevard, Chicago, April 1943, p. 24. 15c.

HEALTH BULLETIN FOR TEACHERS. Available monthly from School Health Bureau, Welfare Division, Metropolitan Life Insurance Company, 1 Madison Avenue, New York. 4 pp.

SCHOOL LUNCHES AND EDUCATION. Vocational Education Leaflet No. 7. Superintendent of Documents, Washington, D.C. 5c.

"TRAINING OF VOLUNTEERS FOR SCHOOL LUNCH PROGRAMS IN WARTIME." *Education for Vic-*

tory, official biweekly of the U. S. Office of Education, Federal Security Agency, Washington, D.C. February 1, 1943, p. 24.

"SCHOOL LUNCHES MUST GO ON." *Consumers' Guide*. Superintendent of Documents, Washington, D.C. February 1943, p. 13. 5c.

"SCHOOL INSPECTORS ARE GIVEN 'MEASURING STICK' IN UNIFORM SANITATION STANDARDS." *Michigan Public Health*. State Department of Health, Lansing, Michigan. September 1942, p. 165.

HEALTH SERVICES IN CITY SCHOOLS. James Frederick Rogers, M.D. Biennial Survey of Education in the United States, 1938-1940. Superintendent of Documents, Washington, D.C. 1942. 50 pp. 15c.

SCHOOLS AWAKE: A Cooperative Community Program in Van Buren County, Michigan. Distributed by W. K. Kellogg Foundation, Battle Creek, Michigan. 1942. 32 pp. Free.

The story of a cooperative community enterprise in which the citizens of Van Buren County, Michigan, move toward a solution of their school problems.

A REPORT OF A JOINT COMMITTEE ON HEALTH PROBLEMS IN EDUCATION. National Education Association, Washington, D.C. 1943. 40 pp. 15c

"DISCOVERING THE STUDENT WITH IMPAIRED VISION IN THE SCHOOLS." James Houloose, M.D. *Journal of Health and Physical Education*, 1206 16th Street, N.W., Washington, D.C. December 1942, p. 578. 35c.

Dr. Houloose presents visual impairments in relation to the education of the whole child in an interesting manner. The physiological, psychological and sociological components of this problem are considered from a different point of view. The school health service's responsibilities are named. Various methods of testing visual activity are evaluated. Certain aspects of the article stimulate further inquiry.

THREE BULLETINS published by Superintendent of Public Instruction and Commissioner of Health, Lansing, Michigan. Free.

A Wartime Health Education Program for Secondary Schools. Bulletin No. 323. 1942. 22 pp.
The Health Services in the School. Bulletin No. 321. 1941. 31 pp.

Teacher Observation of Health Conditions of School Children. Bulletin No. 325. 1942. 31 pp.

SCHOOL CHILDREN AND WAR SERIES. U. S. Office of Education. Superintendent of Documents, Washington, D.C. 1943. 5c each.

Leaflet No. 1—School Services for Children of Working Mothers: Why? What? How? Where? When? 6 pp.

Leaflet No. 2—All-Day School Programs for Children of Working Mothers. 12 pp.

Leaflet No. 3—Nursery Schools Vital to America's War Effort. 12 pp.

"WARTIME CHANGES IN EDUCATION: Which of Them Should Survive the War?" A Symposium. *Understanding the Child*. National Committee for Mental Hygiene, 1790 Broadway, New York. June 1943, p. 3. 15c.

CHILD HEALTH

THE DIRECTORY OF CONVALESCENT HOMES, CAMPS AND SCHOOLS. American Heart Association, 1790 Broadway, New York, May 1943.

"RHEUMATIC FEVER IN CHILDREN." Betty Huse, M.D. *The Child*. U. S. Department of Labor, Children's Bureau, Superintendent of Documents, Washington, D.C. May 1943, p. 158. 5c.

Brings the problem of rheumatic fever among school age children clearly to the front as a public health program and suggests action necessary to cope with it. Gives an excellent reference list and indicates that a limited supply of reprints will be available from the Children's Bureau.

BACK TO SCHOOL! Suggestions for a Fall campaign to reduce child labor and encourage attendance at school during the new school year. Children's Bureau and Office of Education, Washington, D.C. August 1943. 12 pp. Free.

DENTAL HEALTH

HIGH SCHOOL VICTORY CORPS PHYSICAL FITNESS DENTAL PROGRAM. Council on Dental Health. *The Journal of the American Dental Association*, 222 East Superior Street, Chicago, April 1, 1943, p. 593. 50c.

"DENTAL HEALTH FOR YOUTH AND ADULTS."

Michigan Public Health, Michigan Department of Health, Lansing. November 1942, p. 203.

EYE HEALTH

"AN EYE HEALTH PROGRAM FOR SCHOOLS." Prepared by members of National Society for the Prevention of Blindness. *The Sight Saving Review*, 1790 Broadway, New York, Spring 1943, p. 22. 50c.

This is a practical article setting forth five objectives of an eye health program in schools in a manner easy to interpret and apply in the average school system.

SOCIAL HYGIENE

SOCIAL HYGIENE NURSING TECHNIQUES. Nadine B. Geitz, R.N. American Social Hygiene Association, 1790 Broadway, New York. 2nd edition, 1943. 77 pp. 25c.

THE MANAGEMENT OF GONORRHEA IN GENERAL PRACTICE. Special Committee, American Neisserian Medical Society. *Veneral Disease Information*. U. S. Public Health Service. May 1943. p. 127. 5c.

A manual of procedure in the diagnosis, treatment and public health control of syphilis and gonorrhea.

INDUSTRY

A VICTORY COMMITTEE FOR HEALTH AND SAFETY. Industrial Hygiene Service, State Department of Health, 637 Broad Street Bank Building, Trenton, New Jersey. Free.

Leaflet explaining a 3-point program that a workers' committee may undertake for workers' health, safety and welfare.

GENERAL

THE WHAT AND HOW OF COMMUNITY COUNCILS. Dr. E. de S. Brunner. U. S. Department of Agriculture, Extension Service Circular No. 403. March 1943. Free.

A PROGRAM OF WELFARE AND PROGRESS IN HEALTH AND LONGEVITY. Louis I. Dublin, Ph.D. Chapters 20 and 21 from "A Family of Thirty Million." Metropolitan Life Insurance Company, 1 Madison Avenue, New York, 1943.

AN ELEMENTARY LESSON ON CANCER. Edmund G. Zimmerer, M.D. *Iowa Public Health Bulletin*, July, August, September, 1942, State Department of Health, Des Moines, Iowa. 11 pp. Free.

NOTES FROM THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

AMERICAN WAR-COMMUNITY SERVICES

Six leading national social and health agencies of which the NOPHN is one have combined in an organization called the American War-Community Services for the joint financing and planning of their special war-service projects. The other five are: Child Welfare League of America in the field of day care and child protection, Family Welfare Association of America in family casework service, National Institute for Immigrant Welfare working with the foreign-born, National Urban League dealing with problems of the Negro race, and the National Board, Young Women's Christian Association, concerned with special problems of young women and girls. In campaigning for special funds, all alike have the specific purpose of meeting new war-created needs in localities where facilities are either non-existent or notoriously inadequate. The appeal is approved by The President's War Relief Control Board, The National War Fund (its own responsibility being limited chiefly to overseas relief and agencies directly serving the armed forces), and Community Chests and Councils.

AWCS is responsible initially for raising and distributing the six combined war-project budgets totalling \$710,000 for an 18-month period, July 1943 to January 1945. Participation directly in state and local war chests will be sought. AWCS will also serve as a channel to develop working relationships on both local and national levels. It is governed

by a Board of Directors made up of representatives of labor, industry, war chests and the participating agencies.

NOPHN through its share in the AWCS budget proposes to help bring public health nursing services to war-communities. In 1940, over 600 cities of 10,000 and more population lacked an organized resource for home care of the sick. Fully four fifths of these are now war-industry or extra-military areas with all the exaggerated health problems which come with overnight doubling and trebling of populations. Hospitals where they exist are desperately overcrowded and untrained care at home is a poor alternative. With the constant increase of the needs of the military forces for nurses, resources remaining for the civilian population must be fairly and efficiently distributed through a well organized community nursing service.

With its share of the total budget \$83,616, NOPHN plans to develop and maintain a staff of public health nurse field workers. As a first step they would review the situation in regard to public health nursing facilities in war-communities which have no organized service. Fifty or more most critically in need of help would be selected. In these NOPHN would plan with health officials and citizens how best to establish community public health nursing services and would assist with securing necessary personnel.

AWCS points out:

Nursing care of men, women and children who are sick at home will reduce industrial absenteeism and will help reduce the extreme pressure on hospitals. Home maternity nursing

NOPHN NOTES

before, during and after delivery will also ease hospital overcrowding. The health of children in day care centers will be guarded by public health nursing services where no full-time nurse can now be obtained.

AWCS new headquarters are at 130 East 22nd, New York, 10, N.Y. Perry B. Hall is executive secretary.

ORTHOPEDIC NURSING

A three-session group conference on orthopedic nursing will be held October 11 in New York City preceding the annual convention of the American Public Health Association. This conference is primarily for nurses actively engaged in orthopedic services. Discussion will center around plans for future adjustments in orthopedic programs.

Morning session, 9:30-12:00: "Teaching Responsibilities of the Orthopedic Public Health Nurse"

Afternoon session, 2:00-4:30: "Nursing Problems in the Care of Patients with War Injuries"

Evening session, 7:30-9:30: "Orthopedic Disabilities of Workers in Industry"

The morning session, because of informal discussion, will be limited to 30. There will be no restrictions on the afternoon and evening sessions. The conference will be held in the Henry Street Auditorium, 262 Madison Avenue, New York, N.Y. Registration will close October 1 and applications should be sent to Jessie L. Stevenson, consultant in orthopedic nursing, Joint Orthopedic Nursing Advisory Service, 1790 Broadway, New York, 19, N. Y.

• A pamphlet, "Nursing Care of Patients with Infantile Paralysis—Including Nursing Aspects of the Kenny Method," has been prepared by the Joint Orthopedic Nursing Advisory Service together with a committee of agencies working with the Division for Physically Handicapped Children of the New York City Department of

Health. Diagrams for the placing and cutting of packs are included. This pamphlet is being published by the National Foundation for Infantile Paralysis for general distribution. Free copies may be obtained by writing to the Foundation, 120 Broadway, New York 5, New York.

• Amelia H. Grant retired on July 31 as director of the Bureau of Nursing of the New York City Health Department, which position she has held since 1928. Miss Grant was president of the NOPHN from 1934 to 1938.

HONOR ROLL

Hail to the 261 agencies that have been awarded Certificates of Honor since the last published Honor Roll list. These agencies have reported that every member of their regular full-time staff is a member of the NOPHN.

If your agency does not have a Certificate of Honor, indicating 100 percent staff enrollment in the NOPHN, why not ask your staff if they are members of the NOPHN? We shall be delighted to send you a Certificate of Honor and include the name of your agency on the next published list, as soon as you let us know you are eligible.

ALABAMA

Abbeville—Henry County Health Department
Chatom—Washington County Health Department

*Greensboro—Hale County Health Department
Huntsville—Metropolitan Life Insurance Nursing Service

LaFayette—Chambers County Health Department

Oneonta—Blount County Health Department

*Troy—Pike County Health Unit

ARIZONA

Clarkdale—Public Schools

Peach Springs—Truxton-Canon Indian Nursing Service

*Agencies which have been on the Honor Roll for five years or more.

PUBLIC HEALTH NURSING

- Phoenix—Nursing Division—Arizona State Health Department
 *Prescott—County Health Department
 *Tucson—Mothers' Clinic for Planned Parenthood
 *Tucson—Tucson-Pima County Health Service
 *Yuma—County Public Health Unit
- ARKANSAS**
 *Fort Smith—Metropolitan Life Insurance Nursing Service
 *Magnolia—Columbia County Health Unit
 *Salem—Fulton County Health Unit
 *Waldron—Scott County Health Department
- CALIFORNIA**
 *Bakersfield—Metropolitan Life Insurance Nursing Service
 *Eureka—Humboldt County Health Department
 *Fresno—Metropolitan Life Insurance Nursing Service
 *Palo Alto—Metropolitan Life Insurance Nursing Service
 *Pittsburg—Public Schools
 *Riverside—Metropolitan Life Insurance Nursing Service
 Riverside—Junior Aid Visiting Nurse Service
 Roseville—City Grade School District
 *Santa Ana—Metropolitan Life Insurance Nursing Service
 *Santa Barbara—Visiting Nurse Association
 *Stockton—Metropolitan Life Insurance Nursing Service
- COLORADO**
 Castle Rock—Douglas County Public Health Nursing Service
 Hugo—Lincoln County Nursing Service
 *Johnstown—Public School
 Leadville—Health Unit
 *Littleton—Arapahoe County Health Department
 *Pueblo—City Health Department
 Steamboat Springs—Routt County Nursing Service
- CONNECTICUT**
 *Darien—Public Health Nursing Association
 East Haven—Public Health Nursing Association
 *Madison—Public Health Nursing Association
 New Milford—Visiting Nurse Association
 *New Britain—Visiting Nurse Association
 *Norwich—Public Health Nursing Department of the United Workers
 *Willimantic—Visiting Nurse Association of the Town of Windham
- FLORIDA**
 *Fort Lauderdale—Broward County Health Department
 Jacksonville—Duval County Health Unit
 Pensacola—Metropolitan Life Insurance Nursing Service
 *Sanford—Seminole County Health Department
- GEORGIA**
 Albany—Southwestern Regional Office of Georgia Department of Public Health
 Gibson—Glascok County Health Department
 Winder—Barron County Nursing Service
- IDAHO**
 *Kellogg—Bunker Hill and Sullivan Mining and Concentrating Company
 *Pocatello—Metropolitan Life Insurance Nursing Service
- ILLINOIS**
 Cambridge—Henry County Sanitarium Board
 Carbondale—Metropolitan Life Insurance Nursing Service
 *Carlinville—School Health Service
 Centralia—Metropolitan Life Insurance Nursing Service
 *Charleston—Eastern Illinois State Teachers College
 *Freeport—Amity Child Welfare Society
 *Freeport—Board of Education
 Glencoe—Board of Education
 Jacksonville—Board of Education
 *Mt. Carmel—Wabash County Nursing Service
 Princeton—City and School Health Service
 *Sterling—Whiteside County Sanitarium Board
- INDIANA**
 *Gary—Lake County Tuberculosis Association
 *Greensburg—Decatur County Nursing Service
 *Indianapolis—Indiana State Board of Health
 Bureau of Public Health Nursing
 Madison—Jefferson County Health Department
 *Muncie—Ball State Teachers' College Nursing Service
 Terre Haute—Public Health Nursing Association
- IOWA**
 Burlington—Des Moines County Health Unit
 *Cherokee—Board of Education
 Clinton—County Nursing Service
 Council Bluffs—District Health Service No. 11
 Davenport—Scott County Nursing Service
 *Des Moines—Iowa Tuberculosis Association
 *Dubuque—County Public Health Nursing Service
 *Indianola—Board of Education
 Iowa City—Public Schools
 *Iowa City—State Services for Crippled Children
 Knoxville—Marion County Public Health Nursing Service
 *Manchester—District Health Service No. 8

NOPHN NOTES

- *Oskaloosa—Public Schools
- *Rock Rapids—Lyon County Nursing Service
- Rockwell City—Calhoun County Nursing Service

KANSAS

- *Arkansas City—Nursing Association
- Coffeyville—Montgomery County Health Unit
- *Emporia—Board of Education
- Great Bend—Public Schools Nursing Service
- Kansas City—Wyandotte County Tuberculosis & Health Association
- McPherson—County School Nurse
- *Newton—Public Health Nursing Association
- *Salina—Board of Education
- Wakeeney—Trego County Public Health Nursing Service
- *Wichita—Coleman Lamp and Stove Company
- *Wichita—Tuberculosis Association
- *Winfield—Board of Education

KENTUCKY

- Brandenburg—Meade County Health Department
- *Lexington—Public Health Center
- Marion—Crittenden County Health Department
- Smithland—Livingston County Health Department
- *West Liberty—Morgan County Health Department

LOUISIANA

- Franklin—St. Mary Parish Health Center
- *Gretna—Jefferson Chapter, American Red Cross Nursing Service
- New Orleans—City Health Department

MAINE

- Auburn—Board of Education
- Rockland—District Nursing Association

MARYLAND

- Towson—Baltimore County Metropolitan Life Insurance Nursing Service

MASSACHUSETTS

- *Everett—John Hancock Mutual Life Insurance Company
- *Newtonville—Newton District Nursing Association
- Spencer—Good Samaritan and District Nurse Association

MICHIGAN

- *Ann Arbor—Public Health Nursing Association
- Ann Arbor—Washtenaw County Health Department
- *Grand Rapids—Bureau of Public Health Nursing—Health Department

- *Lansing—Bureau of Public Health Nursing, Department of Health
- Newberry—District Health Department No. 6

MINNESOTA

- Aitkin—County Nursing Service
- *Bemidji—District Office No. 1—Minnesota Department of Health
- Crookston—Sunnyrest Sanatorium
- Duluth—Minnesota Arrowhead Chapter, American Red Cross
- Hopkins—Public School
- Little Falls—School Nursing Service
- Rochester—District No. 3—Minnesota Department of Health
- St. Paul—Industrial Nurse Service—Griggs Cooper
- Sauk Center—School Nursing Service
- Willmar—Public Schools

MISSISSIPPI

- *Philadelphia—Choctaw Indian Agency

MISSOURI

- Columbia—Missouri State Crippled Children's Service
- *Harrisonville—Cass County Health Department
- *Jefferson City—Metropolitan Life Insurance Nursing Service
- Kahoka—Clark County Public Health Nursing Service
- Owensville—State Board of Health, District No. 9
- *Rock Port—Atchison County Public Health Service
- Sikeston—Missouri State Board of Health, District No. 2
- *Springfield—Metropolitan Life Insurance Nursing Service
- Warrensburg—Johnson County Health Service

MONTANA

- *Butte—Metropolitan Life Insurance Nursing Service
- *Dillon—State Normal College—Public School System
- *Great Falls—Metropolitan Life Insurance Nursing Service
- Hamilton—Ravalli County Health Unit
- *Missoula—Metropolitan Life Insurance Nursing Service

NEBRASKA

- Lincoln—Division of Child Welfare and Service for Crippled Children
- Omaha—Nebraska Tuberculosis Association

NEW HAMPSHIRE

- Belmont—School District
- Canterbury—School District
- Chichester—School Board

PUBLIC HEALTH NURSING

- *Groveton—Public Health Nursing Association
- Loudon—School District
- Newbury—School District
- Salisbury—School Board
- Warner—School District

NEW JERSEY

- *Dover—Metropolitan Life Insurance Nursing Service
- Gibbstown—Greenwich Township Board of Education
- *Long Branch—Public Health Nursing Association
- Newark—Visiting Nurse Association
- Toms River—Dover Township Board of Education
- *Trenton—New Jersey State Department of Public Instruction
- Woodbridge—Middlesex County Girls Vocational School

NEW MEXICO

- *Alamogordo—Otero County Health Department
- Aztec—San Juan County Health Department
- *Gallup—McKinley County Health Department
- *Los Lunas—Valencia County Health Department
- *Lovington—Lea County Health Department
- *Portales—Nursing Service
- Regina—Lindrith Parish Health Center
- Reserve—Catron County Department of Public Health

NEW YORK

- *Albany—New York State Education Department
- *Buffalo—Tuberculosis Association of Erie County
- *Carmel—District Nursing Association
- *Hartsdale—Union Free School Nursing Service
- *Hornell—Public Schools
- *Lancaster—Metropolitan Life Insurance Nursing Service
- Nyack—Public Health Nursing Service
- Patchogue—John Hancock Mutual Life Insurance Company
- *Plattsburg—Metropolitan Life Insurance Nursing Service
- Rome—Metropolitan Life Insurance Nursing Service
- *Staten Island—Visiting Nurse Association

NORTH CAROLINA

- Clinton—Sampson County Health Department
- Lincolnton—Lincoln County Health Department
- Spray—Rockingham County Health Department

NORTH DAKOTA

- *Bismarck—Public Health Nursing Service
- Devils Lake—Ramsey County Public Health Nursing Service
- Ellendale—Dickey County Nursing Service
- *Fargo—Cass County Public Health Nursing Service
- Forman—Sargent County Public Health Nursing Service
- *Grafton—Walsh County Public Health Nursing Service
- Mandan—Public Health Nursing Service
- Rugby—Pierce County Public Health Nursing Service
- *Valley City—City and School Public Health Nursing Service
- *Wahpeton—Richland County Public Health Nursing Service

OHIO

- *Barberton—Red Cross Nursing Service
- *Columbus—Division of Public Health Nursing, State Department of Health
- *Zanesville—Metropolitan Life Insurance Nursing Service

OKLAHOMA

- Muskogee—Five Civilized Tribes—U. S. Indian Service
- *Norman—Cleveland County Health Unit
- *Oklahoma City—Metropolitan Life Insurance Nursing Service
- Shawnee—Department of Public Health

OREGON

- *Albany—Linn County Health Service
- *Astoria—Clatsop County Health Department
- *Bend—Deschutes County Health Service
- Hillsboro—Washington County Public Health Department
- Heppner—Morrow County Public Health Nursing Service
- *Hood River—County Health Association
- LaGrande—Union County Health Unit
- *McMinnville—Yamhill County Health Unit
- *Medford—Jackson County Health Department
- *Pendleton—Umatilla County Health Unit
- *Portland—Division of Public Health Nursing, State Board of Health
- *Portland—Crippled Children's Division of University of Oregon
- Roseburg—Douglas County Health Unit
- *The Dalles—Wasco-Sherman Health Department
- *Tillamook—County Health Service

PENNSYLVANIA

- Bellefonte—Chapter, American Red Cross Nursing Service
- *Kutztown—Visiting Nurse Association
- *Philadelphia—Henry Phipps Institute

NOPHN NOTES

RHODE ISLAND

- *Barrington—District Nursing Association
- Johnston—School Nursing Service
- *Newport—John Hancock Mutual Life Insurance Company
- *Providence—District Nursing Association

SOUTH CAROLINA

- Bamberg—County Health Department
- *Florence—County Health Department

SOUTH DAKOTA

- *Aberdeen—Public Schools
- *Aberdeen—Brown County Health Department
- Miller—Hand County Public Health Department
- Rapid City—Pennington County Health Unit
- Seiby—Walworth County Public Health Unit
- *Sioux Falls—Board of Education
- *Yankton—Board of Education

TENNESSEE

- *Nashville—Department of Nursing Education—George Peabody College for Teachers

TEXAS

- *Austin—Division of Public Health Nursing Texas State Board of Health
- *Canton—Van Zandt County Nursing Service
- *Dallas—Public Schools—Department of School Health Work
- Dallas—Infant Welfare Association
- Del Rio—Val Verde Nursing Service
- Fort Worth—Tarrant County Health Unit
- *Houston—Anti-Tuberculosis League
- Longview—Gregg County Health Department
- San Antonio—Bexar County Tuberculosis Association
- Tyler—Iron & Foundry Company

UTAH

- *Ogden—Metropolitan Life Insurance Nursing Service

VERMONT

- Montpelier—Womans Club
- St. Albans—Schools Nursing Service

VIRGINIA

- *Charlotte Court House—County Health Department
- *Lynchburg—Metropolitan Life Insurance Nursing Service
- *Newport News—Instructive Visiting Nurse Association

WASHINGTON

- *Asotin—County Health Department
- Ellensburg—Kittitas County Health Department
- *Everett—Metropolitan Life Insurance Nursing Service
- Mt. Vernon—Skagit County Health Department
- South Bend—Lewis-Pacific District Department of Health
- Stevenson—Skomania County Health Department

WEST VIRGINIA

- *Charleston—Public Health Nursing Association
- *Mullens—Wyoming County Health Department

WISCONSIN

- Barabou—Sauk County Health Department
- Brokaw—Industrial and Public Health Nursing Dept. Wausau Paper Mills Company
- *Elkhorn—Walworth County Public Health Nursing Service
- *LaCrosse—City Health Department
- *Milwaukee—Employers Mutual Liability Insurance Company of Wisconsin
- Superior—State Teachers College

WYOMING

- Laramie—Albany County Public Health Department

"SO PROUDLY WE HAIL"

HONORING all war nurses but especially those who served on Bataan and Corregidor, Paramount's fine dramatic motion picture, "So Proudly We Hail," was released throughout the country in August and early September. Portraying Claudette Colbert, Veronica Lake and Paulette Goddard as Army nurses, the picture tells the story of a group of brave American nurses who came through the fires of the Battle of the Philippines.

The picture has excellent possibilities for a tie-up with nationwide efforts for the recruitment of graduate nurses for the Army and Navy

Nurse Corps and students for the U. S. Cadet Nurse Corps. Paramount Pictures will distribute special "So Proudly We Hail" posters to help in recruitment and has prepared a trailer featuring Claudette Colbert making a plea for more nurses for the armed forces, for advance showing. Other aids for local publicity are being planned. The Red Cross urges the whole-hearted cooperation of local recruitment committees with theater managers in order that greatest possible use may be made of the stimulation of interest in nursing which this picture is sure to provoke.

NEWS

Highlights on Wartime Nursing

U. S. CADET NURSE CORPS

"We are here today in a very joyous spirit. We want our student nurses to feel themselves at once part of the great military strength of this country. Nothing could do this as adequately as putting them into uniform. It is our business to make that uniform as style-right and as business-like and as charming as it is humanly possible to do." Thus Congresswoman Frances P. Bolton at a luncheon sponsored by the National Nursing Council for War Service in New York City on August 16 prefaced the showing of three possible wardrobes for the new U. S. Cadet Nurse Corps before a jury of 32

Navy nurse, Army nurse examine the new U. S. Cadet Nurse Corps winter uniform and topcoat



fashion designers. Designs for winter and summer uniforms by Molly Parnis together with a beret by Sally Victor received the winning vote. They are, according to specifications, practical, easy to keep in order, and generally becoming to young women of all types.

This was one more step in the organization of the U. S. Cadet Nurse Corps of which Surgeon General Thomas Parran said: "In my opinion the Bolton Act which authorizes the Corps is one of the most important public health acts ever passed by Congress for the protection of the public health, both civilian and military." The Corps will be administered by the U. S. Public Health Service, Division of Nurse Education, under the direction of Lucile Petry. Mrs. Eugenia K. Spalding is associate director.

To answer personally the flood of questions raised about the Corps, Dr. Parran, Miss Petry and Mrs. Spalding made a swing around the country in August, meeting with nursing school and agency directors in 15 or more key cities.

As plans progress information about the Federal Training for Nurses program will be sent by the Division of Nurse Education directly to presidents of SOPHN's and chairmen of public health nursing sections of state nurses associations. The Division welcomes suggestions as to ways in which schools can be aided so that public health nursing will receive maximum benefits under provisions of the Bolton Act.

By these provisions schools taking part

NEWS NOTES

In Winter, the Cadet Nurse will wear a wool outdoor uniform, left, of soft dark gray. Her topcoat and Montgomery type beret are also gray. The summer uniform, right, is gray and white striped cotton, the belted, reversible raincoat is gray para-troop satin twill. Both uniforms have bright red shoulder epaulets. The Cadet Nurse will wear the official insignia of the USPHS—cap device, lapel ornaments and buttons—in silver. Her upper left uniform sleeve will carry the new Corps insignia, the Maltese Cross in silver against a dark red background.



in the program are required to accelerate their curriculum so that required basic training will take from 24 to 30 months instead of the usual 36 months, where state laws permit. During the 24 to 30 months the student nurse who enlists in the Corps is successively precadet and junior cadet. In some states she may graduate at the end of this period. When 36 months are required the student nurse

continues beyond the junior cadet period as a senior cadet. As senior cadet she can be assigned by the home school where needed for a period of supervised practice up to the time of her graduation—in the home hospital, other civilian hospital, community agency, or governmental hospital. The institution or agency using her services pays her at least \$30 per month and maintenance.

From Far and Near

- On leave for a ten-months' period from the University of Chicago is Eula B. Butzerin, who on August 15 comes to the Red Cross Home Nursing staff at national headquarters in Washington, D.C., to work with Olivia Peterson, assistant director of nursing. The educational programs for instructors of Red Cross Home Nursing will be her special responsibility

Miss Butzerin is a member of the Education Committee of the NOPHN, also of the Committee on Accreditation. She is chairman of the Collegiate Council on Public Health Nursing Education.

- Dr. Ruth E. Grout, specialist in health education, has joined the faculty of the University of Minnesota as associate

PUBLIC HEALTH NURSING

professor of the Department of Preventive Medicine and Public Health and of the College of Education for the coming year. Dr. Grout has been consultant in health education in the U. S. Office of Education, Washington, D.C.

- The Wartime Public Health Conference of the American Public Health Association and related organizations will be held October 11 to 14 at the Hotel Pennsylvania in New York City. Among others the following sessions are of especial interest to public health nurses:

Monday

10:00 a.m., 12:30 p.m. (luncheon), 2:30 p.m., and 8:00 p.m. Special Symposia on Cancer Control.

2:30 p.m. American School Health Association meeting. "Today's Problems in School Health Examinations."

Tuesday

9:30 a.m. "Significance of Today's Experiences for Future Public Health Nursing Practice." (First session of Public Health Nursing Section.)

9:30 a.m. and 2:30 p.m. Workshop on "Adjustments of School Health Personnel in War-time"—in (1) rural communities (2) medium-size communities (3) large cities. (Early advance registration by mail required. Apply to Dr. George M. Wheatley, 1 Madison Avenue, New York, N.Y. State interest in 1, 2, or 3.)

Wednesday

9:30 a.m. Joint session—Industrial Hygiene, Food and Nutrition, and Public Health Nursing Sections.

2:30 p.m. Joint session—Food and Nutrition and School Health Sections, and American School Health Association.

5:00 p.m. Public Health Nursing Section meeting.

Thursday

9:30 a.m. Joint session—Food and Nutrition, Maternal and Child Health, Public Health Nursing, and School Health Sections. Three simultaneous round tables on "Health Standards for Day Care Centers for Children" from (1) state (2) large city (3) small city levels. (Register in advance by mail with Dr. Myron E. Wegman, 411 East 69th Street, New York, N.Y., indicating preference for 1, 2, or 3.)

2:30 p.m. "The Evolving Pattern of Tomorrow's Health."

• The W. K. Kellogg Foundation has made funds available to the U. S. Public Health Service for fellowships in health education leading to a master's degree in public health at the University of North Carolina, Yale University and the University of Michigan. The stipend, \$100 per month for 12 months plus tuition, not only provides 9 months of intra-mural work and 3 months of supervised field experience but also anticipates trainee employment following successful completion of the basic training. Send to Dr. E. R. Coffey, Division of Sanitary Reports and Statistics, USPHS, Washington, for an application blank.

• The National Health Library jointly with the Child Health Education Service of the National Tuberculosis Association has prepared three lists of health education texts for children in the (1) elementary grades (2) junior high school and (3) senior high school. Any of these may be obtained from the National Health Library, 1790 Broadway, New York, N.Y., without charge.

• The Washington State Personnel Board announces merit examinations for the position of public health nurse in the State Department of Health and county health departments with a monthly salary range of \$160-190; and for graduate nurse, to work in a health department with a salary range of \$140-\$160. Applications will be accepted until further notice. Application forms (S. F. 6407) and "Statement of Policies and Rules" may be obtained from the State Personnel Board, 1209 Smith Tower, Seattle 4, Washington. Residence in the state is not required for the examination.

Burns and Wound Infection—New techniques developed in the past year are incorporated in the revised pamphlet "Treatment of Burns and Prevention of Wound Infections" of the Office of Civilian Defense. The revision follows recent

NEWS NOTES

recommendations of the Division of Medical Sciences of the National Research Council which were made for the armed forces and have been modified for civilian use by the OCD Medical Division.

Warning is made that the sulfonamides must be used more cautiously in the treatment of civilian wounds than is necessary in the care of military casualties because "the injured may

(Continued on page A8)

COOKING WITH SACCHARINE

ABOUT four years ago we discovered we had a diabetic in the family which, of course, meant a carbohydrate-free diet for her, which does not sound difficult. For a few months her food was very monotonous and uninteresting, but I found I could use saccharine in some dessert recipes, so proceeded to experiment and produced some very tasty dishes.

Saccharine comes in powder and tablet form. The powdered saccharine is less expensive but difficult to measure as the amount used is very small. It is important not to use too much, as that would be worse than none. So I use the $\frac{1}{2}$ -grain tablets, and get a thousand at a time because it is cheaper to buy them in large quantities. How much they cost depends upon where you get them. I have paid 89 cents, \$1.25, \$1.59 per 1,000, and a thousand go a long way. Individual tastes differ, so the best way to determine the desired amount of saccharine is to experiment a little and decide just how many $\frac{1}{2}$ -grain tablets to use.

I can all my fruit with saccharine, using the same recipes that I used when canning with sugar. The preparation and processing are the same. Boiling water and saccharine are used instead of sugar syrup. Fill sterilized jars with fruit and add desired amount of saccharine. Then fill jar with boiling water. These are the proportions used:

- 1 quart sweet cherries—6 $\frac{1}{2}$ -grain saccharine tablets
- 1 quart sour cherries—10 $\frac{1}{2}$ -grain saccharine tablets
- 1 quart peaches—6 $\frac{1}{2}$ -grain saccharine tablets

- 1 quart pears—5 $\frac{1}{2}$ -grain saccharine tablets
- 1 quart pineapple—8 $\frac{1}{2}$ -grain saccharine tablets
- 1 quart plums—10 $\frac{1}{2}$ -grain saccharine tablets
- applesauce—cook apples with 10 $\frac{1}{2}$ -grain saccharine tablets to a quart

Pickles that require a small amount of sugar, such as bread and butter pickles, are just as good made with saccharine as with sugar. I have not yet discovered how to make pickles requiring a heavy syrup, or jam and preserves with saccharine. However, there is a commercial sugar-free jam that is very nice.

If it is not convenient to do canning, there is a water-packed fruit to which a little saccharine may be added and allowed to stand a few minutes before serving.

This is my custard recipe:

- 1 quart milk, heated
- 6 eggs, slightly beaten
- 12 $\frac{1}{2}$ -grain saccharine tablets
- Seasoning

Put custard in a baking dish, set in a pan of hot water and bake one hour. Serves eight.

In desserts and salads made of plain gelatine, saccharine may be substituted for sugar. A small amount of saccharine may be used in cream— $\frac{1}{2}$ -grain to a pint. All beverages may be sweetened with saccharine.

I hope this gives you some idea of what can be done with saccharine. It has been a boon to us. As we have no growing children there is very little sugar used in my cooking.

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NEWS

(Continued from page 539)

include individuals of all ages and with various types of pre-existing disease, instead of a selected group of healthy young males. The possibility of toxic effects is therefore greatly enhanced. Moreover it is assumed that in civilian injuries, hospitalization will be possible in a relatively short time, whereas in military operations such is not always the case. This usually makes it possible to postpone all considerations of chemotherapy until the injured have been hospitalized."

The emergency care of burns is outlined as follows: "Whenever casualties with extensive burns can be admitted to hospitals without delay, and definitive treatment can be instituted promptly, morphine sulphate, one-half grain, should be administered at the scene of the incident and no local therapy applied to the burned area except sterile gauze to exposed surfaces to prevent infection."

The most notable change in the pamphlet is the withdrawal of the recommendation of the use of ointments or jellies containing tannic acid in the first-aid treatment of burns. The new advice given is that when definitive care cannot be given within two hours, the patient should receive sufficient morphine to relieve pain (not

less than one-half grain, except in patients with lung and bronchial damage, the very old or the very young); and the burned surfaces should be covered with sterile boric acid ointment or petrolatum over which one or two layers of gauze or fine mesh (44) is to be smoothly applied. Over this dressing thick sterile gauze or sterile cotton waste is to be placed and the entire dressing is to be bandaged firmly but not tightly. Substitution of jelly containing 5 percent sulfathiazole in water-soluble base is permissible.

The pamphlet describes "open" and "closed" treatment for burns. The "open" treatment which is now considered the treatment of choice and is especially recommended for treatment of burns of the hands, face, feet, perineum and genitalia, consists essentially of the application of boric acid ointment or petrolatum, with pressure dressings. Such dressings can often be left in place 12 or 14 days.

The "closed" treatment, which is the tanning or eschar method, is particularly indicated in extensive "flash" or second-degree burns of the trunk. This method is recommended only if the following conditions are present: (1) If not more than 24 hours have elapsed (2) if the burned area has not been grossly contaminated

PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

Procurement and Assignment of Nurses

SINCE EARLY summer when a Nursing Division was added to the Procurement and Assignment Service of the War Manpower Commission, much progress has been made in planning for wise use of the country's nurse power in wartime. Plans relating to all fields of nursing were discussed in detail at a meeting in Chicago on September 9 and 10 of chairmen of state committees for nurses of the Procurement and Assignment Service. Brief notes of the meeting appear elsewhere in the magazine (p. 598), also the statements of "Criteria of Essentiality" (p. 543) for public health nurses and for industrial nurses which together with criteria for other fields of nursing were presented at Chicago. These statements were prepared by the Nursing Division with the help of its advisory committees, and approved by the Directing Board of the Procurement and Assignment Service.

Nurses and public health administrators will wish to study these criteria with care. Their application and the recommendations concerning them are still tentative. They doubtless will be changed as use may show that the wording is misunderstood or that there is need for modification in practice.

For the sake of brevity, explanatory statements are omitted. For example, in the recommendation that non-professional technical aides be used to the greatest possible extent in industry, it is understood but not stated that these should work always under the super-

vision of graduate registered nurses. Also, the rather uncompromising statement in the application of criteria for public health nurses that "the staff nurses should be carrying out a generalized service on a ratio of one nurse to 5,000 people" does not mean that every community with more than this number of public health nurses should immediately reduce numbers. The thought back of the statement is positive rather than negative; namely, that if only one generalized public health nurse is serving an area of 5,000 people, this position should always be considered essential. In communities where other health resources are lacking, such as an adequate number of hospital beds, and much bedside care in homes is therefore needed, the number of public health nurses must be larger. Also where a public health nursing agency is extending its service in industrial establishments, a larger number of public health nurses will be needed. All "essentials" must be interpreted in the light of local conditions and relative need. The only fixed element in the problem is that the needs of the military forces *must* be met. Since analysis of community needs and resources and decisions with regard to essential positions are to come from local and state committees composed chiefly of nurses, these local variations will be understood and arbitrary action avoided.

The job of state and local nurses' committees of the Procurement and Assignment Service is just beginning but plans

PUBLIC HEALTH NURSING

are already clear and definite. The committees must in the words of the Directing Board:

1. Procure nurses to meet the needs of the armed forces, with due consideration for civilian nursing needs.

2. Bring about an equitable distribution of nurses in order to maintain the best possible nursing service for the civilian population and non-military governmental agencies.

In order to accomplish this there must be classification of all nurses; determination of the availability for military service or essentiality for civilian service of all nurses eligible for military service; submission of such determinations to the

American Red Cross for use in procurement of nurses for the armed forces; maximum utilization of all members of the profession; maintenance of a complete roster of the nursing profession.

Carrying out these objectives will require effort and sacrifice on the part of the committee members, all of whom are volunteers with full-time jobs of their own. It will mean readjustments and some sacrifice also on the part of individual nurses and the agencies which employ them. Only with the willing cooperation of hospital, public health nursing agencies, patients and nurses can this big but necessary task be accomplished.

"Sharpening the Staff Nurse's Skills"

WHO IS NOT aghast at the breadth and depth of scientific knowledge and sense of proportion required of a good public health nurse doing family health work in 1943? Who does not believe that by and large she turns in a pretty respectable performance—much of it superb? Credit must be widespread. Of course, much goes to basic schools of nursing and to university programs of study in public health nursing, and the financial assistance made available through federal funds. But much credit can also be given to agencies which are giving great care to staff selection and providing sound staff development programs, as well as to the alert nurse who uses these opportunities wisely.

October PUBLIC HEALTH NURSING draws together some of the methods and problems of sharpening the staff nurse's skills being tried in different parts of the country, as well as a few examples of material that has been used in that

sharpening process related to health problems needing new current emphasis.

Some agencies have many resources for this assistance; they can and should be very selective, while others must use their more limited opportunities wisely and drain every value from them. One rural nurse has suggested (p. 575) what can be done by letter and, it is reminded, this type of counsel is available from the headquarters office of NOPHN as well as from the state and county health agency offices. Detroit's originality in using the night delivery service as a staff development opportunity is typical of that highly efficient city (p. 579). Many agencies are trying original plans to help the staff nurse be more effective in orthopedic work. We have given only a few (p. 570, 572).

Two other articles (p. 584 and p. 587) on the work of consultants in special fields remind us there is a knotty problem, prin-

(Continued on page 545)

Criteria of Essentiality

FOR PUBLIC HEALTH NURSES *

Public health nurses who are essential in one of the following positions should be so classified. Those nurses eligible for military service who are essential in one of the following positions will be classified as essential until they can be replaced.

1. Director, supervisor or teacher of public health nurses.
2. Staff nurse rendering a generalized service.**

APPLICATION OF CRITERIA

I. Every effort should be made to replace nurses eligible for military service with nurses who are not eligible for military service and who are qualified to fill such positions.

II. Adequate supervisory personnel should be maintained due to the wartime necessity of utilizing a larger number of less well-qualified staff nurses and non-nursing personnel.

III. The staff nurse should be carrying out a generalized service in a ratio of 1 nurse to 5,000 population, counting those in both public and private agencies.

IV. The designation of a particular nurse as essential in some other capacity than Director, Staff Nurse, etc., as listed in 1 and 2 above should be determined after conference between the administrator of the public health agency involved and the Local Committee for Nurses of Procurement and Assignment Service.

V. When public health nurses eligible for military service are classified as available, preference should be given to those who have not had special preparation for public health nursing.

RECOMMENDATIONS

The Local Committee in studying community needs for public health nurses as a basis for classification will give consideration to the following:

- I. The administration and programs of public health nursing services differ

*Prepared by the Advisory Committee on Public Health to the Directing Board of the Procurement and Assignment Service, War Manpower Commission.

**Report of a committee appointed at the October 1941 meeting of state directors of public health nursing for the purpose of defining the terms *Generalized Nursing* and *Specialized Nursing*. "A Definition." PUBLIC HEALTH NURSING, April 1943. Excerpt, p. 193, "A specialized nursing program is one which consists of a single type of nursing service administered by an agency or one which includes several types of nursing service, each of which is represented in the field by a special nurse or group of nurses."

throughout states, within states, and within localities, this variation being due to historical development, differences in health problems, population densities, and conditions brought about by rapid expansion of war industries and military centers which create special health problems. These variations should be recognized and the total amount of public health nursing available in a community be distributed, as far as practicable, on a basis of priority of need without regard to former special agency objectives, interests, or sources of income.

II. In order to bring about an equitable distribution and economical use of public health nursing services, efforts should be made:

a. To pool all community public health nursing activities since direct services by a variety of specialized public health nurses should be eliminated for the duration of the war as an initial step toward economy of personnel.

b. To prepare all public health nurses for generalized service, regardless of former agency affiliation or special type of service.

c. To mobilize and utilize nursing personnel who have not had preparation in public health nursing and are not eligible for military service for all functions that do not absolutely require public health nursing training and experience.

d. To utilize non-nursing personnel for activities not requiring nursing skill.

III. The classification of nurses as essential who are preparing for positions in essential public health programs. These nurses should be potentially qualified for public health nursing work in order that they may be prepared in the shortest period of time.

IV. Public health nurses not essential for work in the local community should be relocated to areas of special need caused by military and industrial concentrations.

V. The utilization of public health nurses to their fullest capacities for public health nursing duties only with a work week comparable in length to that of other nursing groups in the community.

FOR NURSES IN INDUSTRY*

Nurses employed for nursing service in industry who are essential in one of the following positions should be so classified. Those nurses eligible for military service who are essential in one of the following positions will be classified as essential until they can be replaced.

1. *Industrial nursing consultant* in state or city health departments or labor departments.

2. *Supervisor* who has had preparation and/or experience.

3. *Staff nurse* who is working full time at professional nursing duties.

4. *The only full-time nurse* working full time at professional duties.

APPLICATION OF CRITERIA

Every effort should be made to replace nurses eligible for military service with nurses who are not eligible and are qualified to fill such positions.

RECOMMENDATIONS

In studying the community needs for nurses in industry, the Local Committee should give consideration to the following:

I. Nurses in industry should limit their activities to professional nursing duties connected with the medical department.

II. Industry should utilize existing community resources for nursing services if those resources are adequate to serve its needs.

III. Non-professional technical aides should be used to the greatest possible extent in order to conserve nursing time.

*Prepared by the Advisory Committee on Industrial Health and Medicine to the Directing Board of the Procurement and Assignment Service, War Manpower Commission.

Staff Nurse's Skills

(Continued from page 542)

ciples about which our profession does not seem to be very clear-cut. It is no excuse that other professions have the same problem. Perhaps we can develop principles universally useful. It is hoped that the many employing groups and professional organizations known to be actively studying this problem can soon share and pool any progress they have made. Urgently we need to have some agreement on such problems as:

To what extent does the term *consultant* assure expertness in a particular field?

Are we agreed on the use of the term consultant nurse as meaning an expert nurse adviser in a special field?

What should be the major channel of consultant service: In direct service to patients? In direct assistance to the staff nurses? In assistance to the general supervisors?

Should consultant nurses ever be assigned to areas in which there is no general supervision?

Are the recommended qualifications for consultant nurses as outlined by the NOPHN strong enough? It will be recalled these include such requirements as

general supervisory experience, statistical training, and others.

Is there danger of the consultant and her agency taking on educational responsibilities that should be borne by the nurse and the universities in the nurse's basic and postgraduate training? What proportion of money, raised by tax or contributions, for service to patients can be justifiably spent for such in-service training?

Does a specific consultant service you know stand up under the test of working itself out of a job, particularly in a local agency?

Would a rotation of types of consultants be a practical plan? For example, a consultant in nutrition one year, in cancer control another, and so on.

Have any communities tried the use of a consultant nurse shared by the hospital and public health agency? Would that be advantageous?

If the consultant is not a nurse, but, for example, a social worker, are there advantages in her being employed in her own field part time and part time as consultant?

Doubtless there are many other problems to be raised. We urge you to send them to the NOPHN. Let's establish some principles.

The Needs of the Army Nurse Corps

By COLONEL FLORENCE A. BLANCHFIELD

WE ARE HERE today to consider the nursing needs of the country and how these requirements are to be met.

It was early recognized that there was an insufficient number of graduate registered nurses in the United States to meet the demands of the armed services and at the same time maintain an acceptable nursing service for our civilian population. However, the major problem was one of distribution rather than of numbers, so for more than two years an effort was made by the nursing organizations of the country to influence nurses in essential administration, public health and teaching positions to remain in those positions and to secure a better distribution of all others not in the Army or Navy. Inasmuch as these efforts were not wholly successful, the Procurement and Assignment Service for nurses under the jurisdiction of the War Manpower Board was established.

The Nursing Division of the War Manpower's Procurement Service lists the procurement of nurses for the armed services as its first objective and I have been requested by them to present the needs of the Army.

The number of nurses required by the Army is in direct ratio to its numerical strength. The ratio was set up after exhaustive studies had been made on actual bed requirements for battle casualties in former wars, and the health reports for the Army as a whole over a period of years. One nurse to each ten beds is authorized but it must be remembered

that this number provides for all assignments, such as administrative, supervisory, teaching and professional where bed credits do not exist such as hospital trains and ships, air evacuation units and general dispensaries. The authorized strength of the Corps falls somewhat below the one to ten ratio and our present strength is 3,000 below our quota. Nevertheless, up to this time we have been able to adequately meet our needs for two reasons: The first reason is that we have had an unusually low incidence of illness in our training camps in the continental United States. The second is that we had comparatively few battle casualties prior to the North African invasion and since then fewer than had been contemplated. From this time forward, however, we must be prepared to care for ever increasing numbers of patients, both at home and abroad and returning from overseas.

Our quota of nurses for the fiscal year ending June 30, 1944 calls for over 51,000 nurses. To attain this objective we will have to procure 23,000 during the next 10 months. Of this number, 95 percent may be nurses who have had little or no postgraduate experience provided they are basically well trained, but the other 5 percent must be qualified to fill administrative, supervisory, and teaching positions.

On September 1, 1940, there were 976 nurses in the Corps, 208 of whom had had less than two years of service. Of this number 131 were assigned to overseas service. There were 54 stations to which nurses were assigned and there were few

ARMY NURSE CORPS

hospitals having more than 250 beds and only two having more than a thousand beds.

On September 1, 1943 in comparison, there were approximately 32,000 nurses assigned to more than 1,125 hospitals ranging in size from 25 to over 3,000 beds. I mention these figures in order that you may better understand our need for nurses (in considerable numbers) who are qualified for administrative, supervisory and teaching positions. We are fortunate in having in the service at this time approximately 450 nurses well qualified to organize the nursing service of the hospitals under construction in the United States and for additional units for overseas service. However, replacements will be required for the positions made vacant by such transfers, and it is estimated that 450 will be needed for these assignments and in addition we will need an extra 700 for supervisory and teaching positions for these hospitals.

To compensate for the present shortage of nurses (we are approximately 3,000 below our quota), and to utilize the service of members of the Corps to the fullest extent, the War Department on the recommendation of the Surgeon General has authorized the utilization of Red Cross volunteer nurses' aides; the training of additional volunteer nurses' aides in Army hospitals; participation in the supervised practice of senior student cadet nurses, authorized by the Bolton Act, as they become available; and has directed that all non-nursing duties be delegated to sub-professional groups.

Red Cross Volunteer Nurses' Aides have served in 76 Army hospitals since January of this year, and at present are serving in 32. Five hospitals are conducting classes for additional aides who will, on completion of their training, be available for assignment in those hospitals. Army nurses are assisting in the

training of medical and surgical technicians and are also participating in the training classes of home nursing for wives and members of military families. In the near future they will supervise the nursing of senior cadet nurses who signify their intention of serving the Army after graduation.

There has been considerable criticism of the Army for its procurement of a seemingly oversupply of nurses before they were actually needed. This is easily understood when one looks back over the past two years of "modern" warfare. The success of the so-called "blitzkrieg" method of warfare depends to a large extent on surprise, which was evidenced by December 7th at Pearl Harbor. Fortunately, for us, it was only a nuisance raid designed, apparently, not to capture the island, but to incapacitate the fleet and reduce our offensive forces to a minimum. During the time of the actual combat it would have been impossible to fly medical personnel into or away from the besieged island and all the soldiers wounded in action would have been without the prompt attention so necessary to the preservation of lives, had the attack continued. Fortunately for us, the attack lasted only one day, thus giving our overworked medical and nurse personnel an opportunity to care adequately for the wounded in the comparatively "peaceful" days that followed. This, however, is the problem facing the War Department today, for no one but the enemy knows when and where he is going to strike, nor how long he will be able to continue the attack, and it is up to us to be prepared for *any* eventuality until such time as we can take an offensive action large enough to dictate our own battlefields and therefore control our own medical centers. For the present, however, with aeroplane warfare what it is, we dare not limit our sight to the theaters of war where nurses are

PUBLIC HEALTH NURSING

actually needed. We must attempt to read the enemy's mind and since that procedure is impossible, we can only place our nurses with our troops to play a "waiting" game, a standby insurance policy that may be inconvenient when meeting the monthly payment, but so very valuable when actually matured. The Hospital Division is planning to

activate over 400 more hospital units before June 1944 and this will necessitate more nurses well qualified to fill administrative, supervisory and teaching positions.

Paper given at a meeting of chairmen of state committees for nurses of the Procurement and Assignment Service of the War Manpower Commission held in Chicago, September 9-10, 1943.

Wartime Nursing Is Different

A STATEMENT BY THE DIRECTING BOARD OF THE PROCUREMENT
AND ASSIGNMENT SERVICE, WAR MANPOWER COMMISSION

IT IS UTTERLY impossible to provide the necessary volume of wartime nursing service on a peacetime basis. Places where nursing is going on as usual must share with others. Individual nurses who have not made adjustments to wartime needs for their service should understand the necessity for their participation.

The National Nursing Council for War Service has pointed out that the value of any national plan must be judged by its usefulness at the local level, *i.e.*, where nurses live and work—in the country, in the villages, towns, and cities of the nation.

Wartime nursing is different! That inescapable fact must be generally accepted by nurses, by physicians, and by hospital administrators. Energy and emotion now spent in resistance to change must be released for the attack on war created needs.

Nurses have wrought many changes, but not enough, in the pattern of nursing

service since Pearl Harbor. "We just do the best we can" is heard more frequently than "This is our plan." Generally speaking, educational programs have received more thought than the service programs. Acceleration of the basic course in nursing is an outstanding example. State boards of nurse examiners have initiated others.

The principles of good nursing have not changed, but nurses are learning to concentrate on the essentials. In the analysis and administration of nursing service radical changes are being made. Tremendously valuable assistance in caring for patients is being secured from the Red Cross nurse's aides and other volunteers as well as from paid auxiliary workers.

Thus far nursing service has not been rationed; such rationing would be complicated by the differences in individual nurses and the degree of essentiality of needed services. The sharing of services is more difficult than the sharing of goods.

WARTIME NURSING IS DIFFERENT

A critical shortage of nurses exists. Here are the facts:

Over 36,000 nurses are now with the armed forces and the Red Cross has accepted responsibility for the recruitment of an equal number by June 30, 1944. Our men are receiving skilled medical care of a high order as shown by the high percentage of recovery from injury. Skilled nursing is an important factor in such care. Then, too, the very presence of nurses near the bases of military operations has repeatedly been described as a potent force in maintaining morale.

There has been an unprecedented increase in the use of civilian hospitals. Hospitals gave fourteen and a quarter million more days of care in 1942 than in the preceding year and the trend still is definitely upward. This is in keeping with the rapid growth of the Blue Cross (group hospitalization) plans and the Children's Bureau hospitalization program for the care of the families of service men.

Nursing is essential to the nation's health. The National Nursing Inventories (of nursing resources) of 1941 and 1943, made by the U. S. Public Health Service, offer a comparison of data for the two years (Table I).

The total number of nurses graduated in the two years is well in excess of the number withdrawn for military service; this fact is not apparent in the inventory. The returns are apparently incomplete. Active nurses who did not return their questionnaires apparently did not realize the profound importance of the information requested. This information is the basis for present planning and safeguarding the future.

The relatively small decrease in the number of institutional nurses is much less significant than the increased use of hospitals in creating the serious shortage of nurses. The increased number of

TABLE I
NATIONAL NURSING INVENTORIES

	1941	1943
Total returns	289,286	259,174
Active		
Institutional	81,708	77,704
Public health	17,766	18,900
Industrial	5,512	11,220
Private duty	46,793	44,299
Other	21,276	18,476
Inactive but available for nursing	25,252	38,746 (of these 23,576 are married and under 40)
Inactive, not available	90,979	49,829
In Nurse Corps of Army and Navy	6,371	over 36,000 (precise data not available)

nurses in industrial nursing is, of course, not surprising.

The large number of inactive nurses who reported themselves available is encouraging, but—available for what? Full time? Part time? These nurses and others who are still "hidden" can make a valuable contribution to our nursing resources. Although it requires a little more planning, the service of two part-time nurses can equal that of one full-time one. Wartime nursing puts a tremendous burden on all the administrative nurses.

Nursing leaders were not caught off guard by Pearl Harbor. The Nursing Council for National Defense was the outgrowth of a conference called by the American Nurses' Association in July 1940 for the purpose of coordinating the activities and resources of the profession. Two years later it was incorporated as the National Nursing Council for War Service, with medical, hospital, and lay representation included in the membership. The scope of the program was

PUBLIC HEALTH NURSING

expanded. Foundations and other organizations have contributed generously to its maintenance and to the development of special wartime projects, but leadership has remained in the hands of nurses.

Until July 1 of this year "the Government's Subcommittee on Nursing"¹ which had been set up only a few months later than the council, worked with nurse-employing and other agencies of the government and the American Red Cross, on the one hand, and with the profession as represented by the Nursing Council on the other. Information was quickly shared in order that new tasks could be allocated to the appropriate agency whether federal or voluntary. The effectiveness of this liaison was demonstrated when it became apparent that the nation's nursing resources could not be increased appreciably without federal aid. Successive Congressional appropriations have been secured. Between June 1941, and the end of the last fiscal year the U. S. Public Health Service had disbursed the total sum of \$5,300,000. Assistance had been given to 11,911 students who otherwise could not have entered nursing schools; 4,322 graduate nurses had been enabled to take postgraduate courses; and 3,662 inactive nurses had been given refresher courses.²

On the basis of this splendid record the Bolton Bill was passed without a single dissenting vote. This legislation, which provides for the U. S. Cadet Nurse Corps, has been described by Surgeon General Parran as "the most important

public health legislation ever passed by our Federal Government."

When the nation began moving out of the economic depression the nursing schools (in 1935) began increasing the annual enrollment of students. They did not quite keep pace with the rapidly increasing use of hospital facilities, much less with the total need for nurses, including nurse educators, public health, industrial, and other nurses. This was the situation when the withdrawal of over 36,000 nurses for military service first began.

Wartime nursing is different. The nursing organizations combined and coordinated their forces in the National Nursing Council for War Service. The Council has been the means of securing federal and other financial support of wartime programs. The General Federation of Women's Clubs and other organizations have given unprecedented assistance to nursing. The Council works cooperatively with the hospital association and with government agencies. It is now doing a considerable part of the recruitment for the U. S. Cadet Nurse Corps. It has geared its state and local councils to make effective, at the local level, the program of the new Nursing Division of the Procurement and Assignment Service. The Red Cross recruitment committees are pledged to recruit 36,000 nurses this year. The new division will (1) determine the availability for military service or essentiality for civilian service of all nurses eligible for military service and submit such determinations to the American Red Cross for use in procurement of nurses for the Armed Forces (2) promote plans for maximum utilization of full-time nurses and those who are able to serve only part time (3) develop and maintain a roster of all graduate registered nurses, and (4) develop and encourage sound methods of supplementing

¹ The Subcommittee on Nursing of the Health and Medical Committee of the Office of Defense Health and Welfare Services.

² Data from published report of Hearing Before a Subcommittee of the Committee on Interstate and Foreign Commerce, House of Representatives, 78th Congress, first session, on H.R. 2326, the Bolton-Bailey Bill, pp. 3-5.

SUBCOMMITTEE ON NURSING

the work of nurses with non-professional personnel.

Through the War Manpower Commission, nursing will not only have the benefit of the experience of medicine in the

procurement and assignment of physicians, but means will be found to interpret wartime nursing to physicians and their cooperation secured in effecting desirable wartime adjustments.

SUGGESTED READING

1. Priorities for Nurses. National Nursing Council for War Service, 1790 Broadway, New York, N.Y. May 1943, revised edition.

2. Distribution of Nursing Service During War. National Nursing Council for War Serv-

ice, 1790 Broadway, New York, N.Y. May 1942.

3. Volunteers in Health, Medical Care and Nursing. U. S. Office of Civilian Defense, Washington, D.C.

THE SUBCOMMITTEE ON NURSING GOES ON

ON JULY 1, 1943, two of the major projects initiated by the National Nursing Council for War Service and considered and promoted by the Subcommittee on Nursing of the Health and Medical Committee under the Federal Security Agency, came to maturity; namely, the United States Nurse Cadet Corps under the United States Public Health Service; and the Nursing Division, organized under the Procurement and Assignment Service of the War Manpower Commission.

Thus, two and a half years of analysis of supply and demand for nurses, of lively discussions as to how to meet nursing shortages, and of active participation with medical, hospital, and nursing groups, government officials, and Congress, were concluded. Inasmuch as the new nursing programs under the United States Public Health Service and under the War Manpower Commission both have Advisory Committees and professional staffs, much of the work formerly carried by the Subcommittee on Nursing is being transferred to these new groups. This illustrates an evolutionary process whereby an advisory body reviews needs, presents plans, and gets government sup-

port, then turns over such projects to the proper administrative agencies.

However, the Federal Security Agency is continuing the Subcommittee on Nursing under the chairmanship of Marion Sheahan, with its voting membership of five augmented by the inclusion of Mary Beard, director of Nursing Service, American Red Cross and Alma C. Haupt, director of Nursing Service, Metropolitan Life Insurance Company, who will continue to act as secretary. The functions of the Subcommittee on Nursing as a coordinating group between the nursing services of the Government and as a channel of contact for the National Nursing Council for War Service will be preserved. In addition, the Subcommittee will be available to review the tremendous problems to be faced in postwar planning and to advise the Federal Security Agency in relation to them.

Until July 1, the Subcommittee on Nursing had, in addition to the executive secretary, a public information consultant and carried out a public information program relating to the recruitment of student nurses and the distribution of gradu-

(Continued on page 563)

The Patient Has Cancer

BY ELEANOR E. COCKERILL

THE SUCCESS of any method of prevention or treatment of cancer depends in the last analysis on the patient's own participation. The development of cancer is one of the emergencies of life which puts to a real test the total resources of the individual. Because the nature, cause and probable outcome of cancer are usually "unknowns" for the patient, it requires the greatest security on his part to be able to put himself in the hands of others upon whom he is then dependent for his welfare. Even when he manages to say audibly: "I have a great need. I trust you. I am willing to take a chance," his inner self may really not be able to take the chance and his energy is consumed by fear and worry so that he is actually not able to participate.

Throughout treatment of a patient with cancer, in which clinic and patient attempt the cooperative venture of working together for his ultimate good, several steps or stages seem to be discernible. Briefly these may be said to be first, the seeking of help by the patient; second, the defining of the patient's medical problem; third, the determination of the treatment which will help; fourth, the evaluation of the help given; and fifth, termination of the cooperative venture. Actually in the treatment of cancer, there is no real point of termination, unless the patient dies, because medicine is willing to assume responsibility for watching and observing as long as the patient lives.

THE PATIENT SEEKS HELP

Various factors influence the degree to

which a patient with cancer is able to seek out the help which he needs and much is implied in the actual step of presenting himself for examination and treatment. Inaccessibility of reliable help is becoming less and less of a factor as the number of cancer clinics and hospitals increases. Financial limitations would at first glance seem also to be less significant as society itself assumes more and more responsibility for providing free care for patients with cancer. However, I question whether the provision of free care really allays the true source of the patient's concern about the financial arrangements for his care. Inability to pay may be frightening to some patients because of its implied loss of control of the situation. As one patient put it: "I'd be much surer about what I am a-gettin' if I could lay my money on the counter." Many patients in their minds relate the ineffectiveness of treatment to their inability to purchase the kind of help which they feel would save them. One patient's X-ray treatment had to be stopped abruptly when his skin began to show evidence of irritation. When the case worker saw him later he was in a state of panic because this change of treatment immediately followed his request that he be changed to a free bed. Inability to pay for care may well have special significance for the individual who has cancer because of his constant awareness of fighting against an uncontrollable process. Money always represents one means of buying safety. When the cancer patient has no money he may feel that his situa-

PATIENT HAS CANCER

tion is particularly hazardous and see no way to save himself.

Another factor which has real meaning for the individual who needs the special services of a cancer clinic is the nature of his previous experience with cancer either in himself or someone close to him. Medical science is, of course, extremely interested in evaluating the influence of heredity in the development of cancer. The social worker learns through contact with patients something of the emotional significance for them of the presence of cancer in another member of the family. If their contact with the relative has been a particularly close one, the possibility of deep emotional involvement is real indeed. If death has occurred, we can be sure that the patient has some "scar tissue" resulting from this experience.

Seeking medical help means the assumption of responsibility for doing something about the problem. Many individuals delay seeking help by denying their need for it. This is a pretty vulnerable defense because the evidences of need increase until the patient is compelled to ask for help by the very intensity of his discomfort. Thus he is compelled to become the recipient of help because there seems to be no other way out. His own methods have failed.

These points are emphasized because we need to be aware of the ambivalence, resistance and fear of the unknown which are all parts of the feeling which surrounds the seeking of help. The fact that a patient occupies a chair in our clinic waiting room does not imply that he is in a truly receptive state. The social worker or nurse often renders a most significant service right at this point when the patient's need for support and security are so great. The social worker, in her interview with him, is careful not to minimize the validity of the fears which every part of his body may express and

encourages him to talk about his fears and doubts concerning this new experience. Even when fears are not actually spoken she is able to recognize other channels through which they are expressed. The behavior of the stubborn and demanding patient is for her an indication that this may be his only available means for introducing safety for himself. Insistence upon a certain kind of treatment, demands that the clinic routine be modified for him, are significant of how great may be the patient's need to exercise control for his own defense. The social worker knows that for such a patient, appeal to his intellectual and reasoning powers is futile. Instead she accepts his behavior as a need for relief from his all-consuming fear. She also knows real help will come only through his discovery that the clinic is really a kindly place where his own rights and integrity as an individual are respected and that the clinic staff does care about him and shares his goal of preserving life. It may seem startling to say that the patient has to be helped to discover these things. However, in spite of the clinic's avowed purpose of helping the patient and its sincere desire to do this, the patient's own subjective evaluation of its services may be quite different. Often he views the surgeon as a cruel, punishing person who does things to him, and the nurse as his accomplice. This is not on a reality basis, of course, but rather springs from the patient's projection upon the doctor of his feeling about the disease itself which seems intent upon destroying him.

The following excerpts from an interview reported by Harriett Bartlett* show a little more clearly how the patient may

*Bartlett, Harriett M. "Some Aspects of Social Casework in a Medical Setting." American Association of Medical Social Workers, Chicago, 1940.

be helped to take the initial step toward using the skill which doctor and nurse have to offer. This patient was suffering from carcinoma of the mouth.

Mr. Schmidt's medical history indicated that he was a 65-year-old single man, living alone. He had made an initial visit to the clinic several months before but he became frightened when he was told that he must have an operation, and left without making any of the necessary arrangements. The social worker sent him a letter but he did not respond. Finally, his relatives prevailed upon him to return because of his intense suffering and their concern about him. He was seen again by the surgeon who recommended a very radical procedure and referred him to the social worker for help in arranging admission.

Mr. Schmidt was an erect, slender man, alert and observing. Although he was accompanied by a group of relatives, he sat alone in the clinic at quite a distance from them. When he was ushered into the social worker's office, he looked intently at her and then inquired, "Are you the lady who sent me that letter?" It was explained that this particular worker had not sent the letter to which Mr. Schmidt replied, "It's funny but I have a sister that's the picture of you." He was silent again so the worker said, "Would you like to talk with me about your operation?" His answer was terse and brief, "I'm so afraid of this cutting." The worker was reassuring as she replied, "No one likes to have an operation. Many of our patients are frightened by the idea of it." Mr. Schmidt commented, "I'm afraid of it. I just can't stand it." The worker inquired gently, "Would you rather have the cancer, perhaps, than to undergo an operation?" Again Mr. Schmidt's reply was tersely given, "I've got to do something about it. I thought maybe radium could be used. There was a doctor said that might be tried when I was here last summer. That's been quite a long time ago. Almost a year, I guess. It was so dreadfully hot I couldn't go through with it. I'll show you the letter I got." The worker was shown the letter and as soon as she had read it, she laid it on the desk. Mr. Schmidt immediately picked it up saying, "I always save everything I'm given." Then there was another pause during which Mr. Schmidt looked out of the window. In a few seconds he began to talk again, "I was recommended to come to this place on Monday and I've been trying to get here ever since. But I just couldn't until today." The worker inquired,

"Can you tell me why you have been so afraid?"

Mr. Schmidt's reply was immediate, "Yes, I know. Afraid I would die in the operation. Afraid I would bleed to death. It's fear that kept me away." Again the worker inquired, "What helped you to come today?" Mr. Schmidt hesitated for a moment and then replied, "The advice of a good old honest man. He wanted me to come here, but he's against cutting too. He's been telling me right along I had cancer. Why when I first heard that I felt just like I was going to be electrocuted." Then there was another pause after which he commented, "I've had many hard places in my life. I've got four married sisters. My mother and father and brother are all dead. I've been raised mighty hard." At this point the worker remarked, "You are accustomed to going through hard experiences," to which Mr. Schmidt replied, "This is terrible. I've either got to be cut on or go through the agony of a long slow death. An old friend told me one and a half years ago, 'You'll live a long time with that if you don't let them do any cutting.' Since then I've been using alum water and the like." The worker said, "You are going to have to choose between the advice of friends and that of the doctor." Mr. Schmidt nodded in agreement and said, "Yes, that's the question." Then there was another question from the worker, "Whom do you really trust the most?" Immediately Mr. Schmidt replied, "The doctor." Then a pause followed and abruptly Mr. Schmidt spoke again, "You wouldn't want me to come right away, would you?" He watched the worker's face as he awaited her reply. She said, "No, we will let you decide that for yourself." Mr. Schmidt relaxed somewhat, then said very decisively, "If I could be treated without cutting, I would be relieved a whole lot." The worker made no comment but waited for Mr. Schmidt to speak again, which he did in a few seconds, "If I would make a start to come Monday or Tuesday, how would that be?" The worker replied, "That would be all right." Mr. Schmidt continued, "I would come up, say about noontime on Monday or Tuesday." The worker commented, "It would be a little better if you came about one-thirty." Again Mr. Schmidt looked at the worker intently, "What would happen if I shouldn't come at all?" She replied quietly, "We would be sorry." "Why?" he queried again. "Because we want to help you," she said. There was a slight pause and Mr. Schmidt commented, "I really believe you do." After this, the tension seemed less and there was some additional interchange of ques-

tions and answers and the interview appeared ended. As Mr. Schmidt made his way to the office door, the worker commented, "Shall I expect you on Monday?" Mr. Schmidt stopped, turned and again looked at the worker as he inquired, "If I don't come on Monday, will you take me off your lists?" To this she replied, "No, we will wait until you are ready." Mr. Schmidt spoke very emphatically, "If it weren't for this cutting business you would be sure I'd be right here on time. As it is, I don't know."

Mr. Schmidt did return and the operation was performed. Throughout his entire hospitalization, his behavior was consistently the same. He continued to be fearful that he would lose control of the situation, he was extremely possessive in attitude toward all of his personal belongings, he reacted negatively to the exercise of any degree of authority over him. However, he recovered sufficiently to be discharged from the hospital and then returned to the outpatient clinic at intervals.

Mr. Schmidt was obviously a very fearful man who was essentially distrustful of people and their intentions. The social worker recognized the fact that any infringement upon Mr. Schmidt's control of the situation would frighten him so badly that he would again have to flee from the clinic. Throughout the interview, Mr. Schmidt was permitted to bargain with the worker and many times he put her to the acid test with a direct question. As the interview progressed, he began to feel that she was a safe person to whom he might entrust himself. There were many more interviews with Mr. Schmidt, the most difficult of which took place on the eve of his operation when the worker was besieged with questions about the details of what would happen to him on the following day. There were questions about how he would be taken to the operating room, how long he would be there, whether he would be put to sleep, whether he would be given anything for his pain afterward, whether he would have to use the bedpan. Each and every one of these questions had to be answered sensitively in order to satisfy Mr.

Schmidt's need for security in the new situation in which he found himself.

THE PATIENT'S PROBLEM IS DEFINED

When our patient has once become a real patient in the sense that he has indicated his willingness to go ahead with study and treatment, the doctor's real task begins—that of identifying what he has to deal with in this particular patient so that adequate treatment can be planned. The doctor uses many diagnostic devices in order to give his patient reliable help. The diagnostic period is often a trying time for the patient. Although his participation may seem to be at a minimum, he is really giving quite a lot of himself. He gives his medical history, a description of how he became ill and the nature of his chief complaint. He enumerates his symptoms. He gives specimens of himself in the nature of blood, urine, feces, bits of diseased tissue. He has pictures taken of parts of his body. He stands behind the fluoroscope while his medical advisers watch the inner workings of his body. Inasmuch as the patient's real purpose in coming to the clinic was to obtain relief from pain and discomfort all of these measures may appear to have little real value because he applies to them the rigid test of how much relief they bring. Also he is wondering, too, what is being learned about him that he does not already know. What do they see inside his body? As his chart becomes thicker and thicker with increasing evidence about the nature of his problem, his tension may increase. Some patients do not return to hear the results because they are sure that help will not be forthcoming. Such a patient may feel that he has been proved unworthy, that he is too "bad" to be helped. During this period of the patient's contact with the clinic he is apt to be considered more as a body than as a person and thus some patients

PUBLIC HEALTH NURSING

feel quite isolated and helpless. It is important to remember that a patient has his own ideas about how he becomes ill and what is the matter with him. As he observes the procedures being carried out and listens to the discussions going on around him, he comes to feel that his own ideas are too queer to express, that they will seem ridiculous. As the gap widens between his own ideas and the clinic's scientific viewpoints, the patient may become apprehensive lest his real difficulty will not be discovered. His own theories, which he cannot express, may erect a wall excluding a view of the usefulness to him of the hospital's activities. Here again we may see the social worker's special function in the clinic. It is her skill to seek out the source of interference and to work with the patient and the clinic to the end of enabling the patient to accept and benefit by the medical care which is available for him. The social worker is in a strategic position to do this because of her knowledge of the working of the clinic and her understanding of the patient and his needs. More specifically, the social worker's process is that of helping the patient to discover that although his own ideas are valid and important for him, his greatest source of help lies in the additional knowledge and skill which his doctor is able to contribute.

TREATMENT IS PLANNED

When sufficient knowledge about the patient with cancer has been gathered to enable the doctor to make a diagnosis, attention is then focused on treatment. The patient is most anxious about what the doctor is going to do for him. It is significant that some of these patients sever their relationship with the doctor or clinic after they discover what the nature of the help will be. This is often confusing and frustrating to those who have offered the help. It seems unreason-

able that he who needs help so badly rejects the means for obtaining it. Here again we must take into account the patient's own theories, his concept about what will be good for him, but a general knowledge of the factors which create anxiety is valuable.

When the doctor recommends radical surgery it may be that this represents the patient's choice, too. Many patients with cancer feel that their only hope for recovery lies in the removal of the offending and attacking mass within them. Surgery has special emotional value for the patient who thinks of the cancerous part of his body as representing the "bad" in him. Surgery also may represent a more active kind of intervention in his behalf than another form of treatment. We must remember, too, that the patient's feeling about surgery may reflect the general attitude of the public. In general, the doctor's willingness to operate seems to indicate that there is hope for the patient. On the other hand, we must recognize that surgery has dangerous implications for many patients. Not only is there the fear of immediate death as a result of it but some patients cannot bear the thought of living if their body is to be anything less than whole. Certain parts of the body are harder to give up than others. One patient who had been advised to undergo radical surgery for carcinoma of the breast said, "I can't help thinking of the way I'm going to look. I never wanted to have any part of my body removed. This will make me lopsided."

Patients react in varying ways to treatment by X-ray and radium. One patient failed to return to the clinic after her first X-ray treatment. When a worker went to her home to learn the reason, she discovered that this patient felt that X-ray could not possibly help her. She said, "I was feeling awful bad and thought I would never manage to get to the hos-

PATIENT HAS CANCER

pital. Then they just put me in front of a little window and let a draft blow on me. Drafts always were bad for me and anyway I want treatment that will do some good." Many patients with cancer have difficulty in accepting the increased pain and localized reaction which may follow the use of X-ray and radium. This is understandable when we realize that there is no immediate relief for the patient, no evidence that the doctor has selected the right kind of treatment. Some patients can bear temporary disappointment in the hope that there will be ultimate relief. The anxiety of other patients is so great that they cannot see ahead to this end. With limited capacity for trusting others, these patients must protect themselves by escaping from the situation.

EVALUATING TREATMENT

After the maximum treatment has been given, the follow-up period ensues. In essence, this is the period in which the effectiveness of the treatment is being evaluated. The clinic may be much more aware of the need for follow-up than is the patient. The patient measures his recovery in terms of well-being and comfort. His visit to the follow-up clinic may bring the greatest satisfaction to the staff when a cursory examination shows that the disease process has been halted. However, many patients who are in the follow-up stage of care express profound disappointment when the doctor looks at them briefly and asks that they return again in a month. There is little value for them in this casual contact and, in fact, considerable anxiety may be aroused. Some of these patients may have to go through the same struggle at the time of a follow-up visit to the clinic that accompanied their first visit. What new danger will have to be faced on reexamination? Some individuals prefer ignorance of their

true condition to the anxiety aroused by clinic attendance.

Then, too, there may be a difference between the clinic's measurement of effective treatment and the patient's own evaluation of the help which has been given. The clinic's chief goal is the preservation of life itself. The patient may not feel that mere permission to live compensates him adequately for the necessity of living with a disfigured body or one in which the normal way of functioning has been altered. Many patients do not participate in follow-up because of the hostility which they feel toward the clinic in which these things happened to them. Probably it is safe to assume that a broken relationship with the clinic implies that the patient has not found his experience there helpful or satisfying enough to warrant his return. The social worker operates on this basis when she seeks the patient's participation in follow-up. The paramount question in her mind as she approaches the "delinquent" patient is "How has the clinic failed to be helpful to the patient?" rather than "Why is this patient so stupid as to refuse the help of the clinic?" With this focus, she begins with the patient's feelings about his experience in the clinic and helps him to work through these feelings so that he can again become a participating member of the group so willing to help him and thus serve his own greatest good.

THE TERMINAL PATIENT

And what of the patient whom we cannot help? We usually think only of the problems created by this situation for the patient but it is helpful, too, to think about the problem which inability to help creates for us. Here we have not only to cope with our own feeling of inadequacy and failure but we have to accept the hostility and criticism of the patient

PUBLIC HEALTH NURSING

and his family as well. We are not really free to give the patient the emotional help he needs unless we are free from the need to defend ourselves, to reassure our own fears. We should always examine what we do and say during this period with a critical eye as to what needs of our own are being satisfied. If we cannot bear the idea of death for ourselves or our loved ones, we will be unable to help others

to face it. If, unconsciously, death would have value for us as a means of escaping from a life which is difficult and painful, we may project our own feeling upon the patient and think that it is better for him to die than to live. In the terminal stage, more than any other, we need to discover the patient himself, and to accept the fact that death, as a part of life, is a very individual matter.

POSTGRADUATE TRAINING UNDER THE BOLTON ACT

When the call was issued for 65,000 student nurses this year, there was an extra, and equally important, appeal for graduate nurses to train as teachers for the recruits and in other important fields of nursing. Graduate nurses now engaged in their profession or temporarily retired, are needed by wartime America as head nurses, supervisors and administrators of nursing services and as instructors and administrators in nursing schools. Their service is required particularly in such fields as industrial nursing and venereal disease nursing.

The essentiality of this need was recognized by the Congress in the recent passage of the Bolton Act. This bill includes provision for postgraduate programs to prepare graduate nurses in the performance of vital administrative and teaching functions and for refresher courses to bring the inactive graduate nurse up to date in present methods of nursing treatment.

Administered by the U. S. Public Health Service, the Bolton Act provides funds for advanced training in preparation for nursing service positions, including work in clinical fields, public health nursing organizations and hospitals, with

out-patient departments included in the latter. Funds are also allocated to train nurses for faculty positions in institutions offering basic or advanced nursing curricula, for without faculties our expanded schools cannot continue; and they must continue.

Postgraduate programs for which federal funds are granted may be regular programs leading to a degree or may be realigned and so modified as to meet wartime demands.

Federal funds are allotted also to hospitals for supplemental clinical courses, such as medical, surgical, obstetric, pediatric, communicable disease, and psychiatric nursing. These courses are designed to assist graduate nurses in supplementing basic nursing preparation required for advanced programs in nursing education or to make them eligible for membership in the War Nursing Reserve of the Red Cross.

In addition, clinical courses are conducted to provide experience in a field in which the nurse has had little experience since graduation. They are designed to acquaint graduate nurses with current nursing technique and to familiarize

(Continued on page 569)

"Oh Nurse, the Baby Is Coming and the Doctor Isn't Here!"

By LALLA MARY GOGGANS, R.N.

WHAT WOULD you do if you were in a patient's home making a visit and someone rushed in and cried, "Come quick, Mrs. Crandall is about to have a baby and the doctor isn't here!" Or suppose you were riding down the road and a frantic husband stopped you to say, "My wife has just had a baby and I am all alone with her. Please help me!"

Public health nurses, especially those working in rural areas, are being called on daily to meet just such emergencies. Every public health nurse can and will want to be ready to step in and do a good job. She can if she is prepared to meet the emergency.

In rural areas there is little equipment to work with and it just isn't possible to send to the corner drug store. The nurse will have her visiting bag and she can make much use of it, but the following additional supplies will be necessary because, in all probability, she will have little time to round up anything.

EMERGENCY OBSTETRICAL PACK

1. 2 newspaper pads made from 12 thicknesses of newspapers spread out to full size.
2. 1 hand towel, or paper towels can be used.
3. Hand brush and orange wood stick for scrubbing and cleaning your hands.
4. 1 cake of soap—half for washing and

scrubbing your own hands and the other half for preparing the mother.

5. 6 sterile pads or sponges, 3x3 inches—2 for cord dressings, 4 for wipes for baby's eyes and nose.
6. 1 clean apron.
7. 1 pair of blunt scissors for cutting the cord. If you have surgical scissors in your nursing bag you won't need them.
8. A razor and new blade for shaving the mother.
9. 3 pieces of cord tape, cut in 12-inch lengths to tie baby's cord.
10. 2 ampules of silver nitrate, 1 percent—drops for baby's eyes.
11. An envelope containing birth certificate blanks.
12. A clean piece of old sheet or muslin, just in case you have to do some improvising, say for the baby's binder or covering for your hair, a mask, wipes, etc.

These supplies can be purchased for about \$1 and should be wrapped in an unbleached square and then securely tied in a dark blue denim cover to keep clean. None of the supplies need to be packed sterile except the sterile pads or sponges which may be bought in sealed waxpaper covers.

PREPARING THE PATIENT AND SUPPLIES FOR A CLEAN DELIVERY

On entering the home, take a quick look at the patient and see how far she

PUBLIC HEALTH NURSING

has advanced in labor. If the baby has not arrived, find out what time the pains began, how often they are coming, if the waters have broken, if there is any bleeding. Tell the mother and her family that everything is going to be all right. If the doctor doesn't arrive in time, you can carry on and there is no need to be afraid.

Usually neighbors, friends and family will be crowded in the room with the patient, but it would be wise if just one person stays in the room to assist you. She should have clean hands and do only the things you assign to her.

THREE THINGS TO REMEMBER

There are three main things to remember for the prevention of infection during labor.

First. Prevent potential infecting organisms from outside sources from being deposited on the external genitalia or adjacent area. This includes sources such as droplet infection from nose and throat, unclean hands, or from other agents being brought into contact with the patient.

Pull up a table, trunk or dresser near the bed, within easy reaching distance. Cover it with newspapers and open your emergency pack. Your nursing bag can be placed on a nearby chair or box. Take out the things you will need for scrubbing your hands and the following articles that must be boiled for 10 minutes—scissors, cord tapes—which can be boiled together in a small stewpan or enamel container from your nursing bag. Take out also about 2 dozen 5x5-inch clean cloth squares or large cotton balls for keeping parts clean before, during and after the baby is born. Boil in a covered basin or pan.

Your helper can protect the bed with several thicknesses of newspapers and make it up with clean sheets. If the

patient is still up, she should go to bed because you can easily be fooled by the frequency and length of contractions and her general appearance.

While washing your hands, take a quick look at existing facilities in the kitchen. Two covered containers of boiled water will be needed; one hot, the other cool. It is a good idea to check on the water supply on hand because in many rural areas water still has to be pumped. You will also need to see that there is plenty of wood to keep the fire going.

After putting on your apron, cover your hair with a clean square of cloth—a diaper can be used for this—and cover your nose and mouth with a mask. One can easily be improvised with a clean piece of cloth or a handkerchief.

Now, take a more thorough look at the patient. If the baby is born when you arrive, you still want to do these things, but you should first see that the mother and baby are all right. Take your time and don't get excited.

Second. Cleanse the perineal field in order to prevent migration, transportation or growth of organisms from this field into the vagina.

If you have time the external genitalia and pubic region should be shaved before the baby comes and this can be done in a very few minutes. If the patient is shaved, the genitalia should be thoroughly washed, from above downward, the abdomen to the umbilicus and the thighs to the knees, with soap, warm water and a clean washcloth, taking care that the soapsuds and rinsings don't come in contact with the vaginal opening.

Third. Prevent the existing bacterial flow in the vagina from being carried into the uterus.

Nothing should be put into the vagina and the patient should be instructed to keep her hands away. The bladder should be emptied at regular intervals.

THE BABY IS COMING!

As the baby's head passes down into the pelvis, small particles of feces are frequently expelled, especially if the patient has not had an enema, and they should be wiped off at once with toilet paper or clean cloth wipes.

The bed under the patient should be kept dry and clean.

THE BABY COMES

While the baby is on the way the nurse stands by. She maintains an air of quiet confidence in the labor room. She keeps the atmosphere as normal as possible and deals positively with each situation as it arises. She gives instructions calmly and doesn't fuss or fidget. She keeps her work and materials organized and avoids all untidiness and confusion.

The signs of second stage labor are:

1. The pains become more regular, more frequent, are harder and last longer.
2. The mother may become nauseated and vomit.
3. She may complain of rectal pressure and feel that her bowels have to move.
4. If the membranes have not ruptured earlier, they may do so now.
5. A small amount of mucus mixed with blood—the so-called “bloody show”—comes from the birth canal.

The mother should be watched carefully when she is in her second stage of labor. The basin which contains the boiled wipes and the pan containing the boiled cord ties and scissors can be uncovered. If the wipes are cool, warm boiled water should be added. The sterile pads or sponges for cord dressings and wipes can be undone.

Now in the second stage of labor and not earlier, the mother should be encouraged to push down when she has a contraction. She can flex her legs on her abdomen during a contraction, but as soon as the head *crowns* at the vulva, she should lower her legs to the bed, with her

knees flexed, and pant. Too much force behind the head at this time might push it out too quickly and cause the edges of the birth canal to tear. When the contraction is over, and before another begins, the head will come out much more slowly if the mother pushes just a little. This makes it easier for the nurse to control the birth of the head and may possibly prevent lacerations. The soft parts of a mother who has had more than one baby may dilate very quickly, thus permitting a quick delivery. A mother who is having her first baby will need help and encouragement to complete the second stage of delivery. The experience is entirely new to her and she needs to be taught how to use her pains. Occasionally a mother who has had more than one child will be having a baby for the first time without anesthesia. If this is so, she will need the same careful guidance and instruction. It is very unwise for the nurse to prognosticate the time of delivery, for if she is wrong in her guess, the mother and the family may lose confidence in her ability to handle the situation.

Immediately after the birth of the head, the nurse should feel the baby's neck to find out whether it is encircled by one or more coils of the umbilical cord, for it can usually be lifted gently over the shoulder or over the head, whichever is easier. Support the baby's head with one hand, and with the other, wipe away the mucus from the eyelids, nose and mouth. The baby's head will turn and with the next pain his shoulders and body will be born. Have someone record the time, because you will need this for the birth certificate.

When the baby has arrived, you must then remember that there are two patients to be cared for. First look at the baby. Pick him up by his feet. Hold him by the ankles, with one finger between them so he won't slip out of your hands. Be

PUBLIC HEALTH NURSING

careful that you don't pull on the cord. With your other hand on his forehead, bend his head slightly back so the mucus and fluid can drain out. If he doesn't cry at once, rub your fingers up and down his back to stimulate breathing, but don't spank him. When breathing is well established, and he has a good color, lay him on a clean place, either between the mother's legs or on top of the sheet on the mother's abdomen.

If there are no signs of the separation of the placenta, you can tie the cord at this time and get the baby out of the way so all your attention can be focused on the mother. But there is really no hurry. It can be done later.

Place the first tie 1 inch from the baby's navel and the second one about 1 inch from the first. Be sure to tie square knots, and when drawing the cord tight exert pressure toward the baby so as not to pull on the cord. Cut between the two ties. With a sterile wipe, gently *milk* the stump to see if there is any bleeding. The third cord tape is an extra, just in case. Put the sterile cord dressings on and hold in place with a band. Wrap baby in a warm blanket and put him where he can be watched.

There is usually a brief resting period after the baby is born. Then the uterus will begin to contract with pains to push out the placenta or after-birth. Don't try to hurry it by pulling on the cord. It may not come right away.

SIGNS TO WATCH FOR IN THE EXPULSION OF THE PLACENTA

1. Contractions you can feel with your hands on the mother's abdomen.
2. A trickle or small gush of blood at the vulva.
3. The cord comes farther down as soon as the placenta is pushed from the uterus into the birth canal.
4. The uterus feels rounder, smaller and

harder and rises above the umbilicus as soon as it has expelled the placenta.

At the time of the contractions, the mother should bear down strongly to expel the placenta. Catch it in a basin or newspaper pan. Be sure that all the membranes come with the placenta. Later you will want to inspect it and the membranes carefully, to see if they are all there. If the placenta doesn't appear to be complete, you should save it and show it to the doctor.

WATCH FOR BLEEDING

If the uterus becomes soft, it should be gently massaged and held for about 30 minutes to an hour, or until it is firm. However, if more than one cup of blood is lost before or after the placenta comes, you should send for help. Watch for signs of shock. Remember that the bladder fills with urine rapidly and that this may be the cause of post-delivery bleeding. Usually the mother is able to void if given the opportunity. The uterus that is filled with blood or clots will not contract firmly and remain under control. These precautions frequently prevent excessive blood loss and are within the province of good nursing. If you have standing orders for an oxytocic, this should be used to prevent blood loss as well as to control it.

IMMEDIATE AFTERCARE OF MOTHER AND BABY

Wipe off the blood from the mother's external genitalia with boiled wipes and look for tears. If there are any, they should be reported to a doctor at once. Put on clean perineal pads and a clean pad under the mother and see that she is warm. She should have a hot drink as soon as possible and should lie on her back, with her knees together, and remain absolutely quiet for at least two hours. Her temperature, pulse, respiration and

THE BABY IS COMING!

blood pressure should be taken at this time.

The first thing to do for the baby is put two drops of 1 percent silver nitrate into each eye. Then carefully inspect his body as you give him an oil bath. After he is dressed, he is ready for a drink of warm boiled water and a safe place to sleep.

BIRTH CERTIFICATE

After the mother and baby have been taken care of and you have carefully instructed the family in their care, you can fill in the birth certificate while you catch your breath. If it is done at this time, it will save time and gas later on.

EXIT NURSE

It would be safer to stay with the mother for at least two hours after the baby is born, if you are in a rural area, especially if the place is off the beaten track. Here again, adequate standing orders will help you plan for the continued care of mother and baby.

After it is all over, you will probably find that you are very weary, and you realize for the first time that your carefully planned day is *shot*. But as you leave to make a report to your health officer or to the doctor, you will feel that you really lent a helping hand in a time of great need.

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Subcommittee on Nursing

(Continued from page 551)

ate nurses. Jean Henderson, who carried on this work, is now in charge of the Public Information Service of the Division of Nurse Education of the United States Public Health Service. The Nursing Division of the War Manpower Commission has access to the Public Information Service of that agency. Therefore, it is no longer necessary for the Subcommittee on Nursing to continue this activity.

Correspondence relating to the Subcommittee on Nursing may be addressed to Marion Sheahan, director, Division of Public Health Nursing, State Department of Health, Albany, New York, as chairman; or to Alma C. Haupt, director of Nursing Service, Metropolitan Life Insurance Company, 1 Madison Avenue, New York 10, New York, as secretary.

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An Epidemic of Ringworm of the Scalp

By HAROLD H. MITCHELL, M.D., LAURA S. STORY, R.N.
AND JANE C. MACDONALD, R.N.

AN UNUSUAL incidence of ringworm of the scalp was reported in November 1942 by a nurse in one school of a health center district of 240,000 population. While a few sporadic cases of this disease have usually been recognized each year in a district of this size, no epidemic was anticipated. The experience is reported because it seems so similar to the reports of the problem in England and Europe where the disease has caused great expense and loss of school time. This preliminary report is presented before it is possible to know the adequacy of the control activities that were finally developed at the end of the school year. A further search for new cases will be necessary beginning with the opening of the schools in September this year in order to determine whether there has been a further spread of the infection.

According to the usual practice when there is an unusual incidence of communicable disease, the teachers were, during the late fall and early winter months, given special instruction in the recognition of suspicious signs of the disease.* Teachers referred suspicious lesions of the scalp to the school nurse, and in turn the nurse screened out the children that she suspected had tinea capitis and these cases were referred to the school physician for diagnosis. All cases were followed up to get them under treatment by private physicians or clinics. Cases

were readmitted to school when the private physician reported recovery or there was evidence that the case was actively under treatment. As the old cases were reexamined, it became apparent that cases which had been regarded as cured or under control had relapsed and were sources of further infection.

By January the inspection of all the family contacts including those of obvious ringworm of the glabrous or hairless skin and the referral of suspicious lesions of the scalp by teachers had brought to light about 30 cases in this particular school. However, there was more or less uncertainty about the diagnosis of many of them and the apparently normal appearing scalp that had been under treatment always presented the problem of whether the case was free from infection or not. The advice of a qualified dermatologist was sought and in February he was employed for reviewing all doubtful cases.

EPIDEMIC CHARACTER OF THE OUTBREAK

The condition was then reported to the members of the nursing and medical staff of the district office with the result that about a dozen more cases were recognized in neighboring schools. The routine inspection of children by nurses and physicians in the classroom brought to light other missed cases as well as some that had previously been declared cured and re-admitted to school on the

RINGWORM OF THE SCALP

basis of reports by private physicians or clinics. By the end of February about 50 cases in the epidemic school had been excluded with the help of the dermatologist.

The spread of the disease raised the question whether the organism causing the disease was different from the infection that had usually appeared in this city as sporadic cases. The laboratory reports of several hospital clinics as well as cultures from the city laboratory revealed the prevalence of microsporon Audouini infection. Dermatologists advised that scalp infections with this organism are very resistant to treatment except when X-ray epilation (roentgen ray treatment to remove hair) is available. It was then recognized that X-ray epilation and laboratory facilities were necessary for adequate treatment and more intensive case finding with the Wood's light (ultra-violet ray with Wood's filter) was essential for adequate control.

As most of the cases were under the care of private physicians, the County Medical Society was appealed to for assistance in informing the profession. Prompt action was taken in the form of a resolution which was published in the Medical Society Bulletin and copies were sent to the physicians in the epidemic area over the signature of the president of the County Society and at the expense of the Department of Health.

The delay in obtaining X-ray epilation in most cases and the long absences of the pupils made the school authorities realize the need for active cooperation in all control measures. In every school where one or more cases had been found the school nurse was spending a large part of her time screening out the children referred by teachers and it was evident that teachers were alert in seeing every deviation from the usual appear-

ance of the scalp. Neither the school physicians nor the dermatologists could rely on their clinical judgment in the diagnosis of all the referred cases and even negative cultures gave no definite assurance of freedom from infection. The Wood's light provided the means of definite and rapid case finding. However, this means was not at once available.

Parent-teacher associations in four schools were persuaded to purchase Wood's lights and the Mycology Department of Vanderbilt Clinic took over an epidemiological study in two schools. This assistance supplemented the Wood's light facilities of the Department of Health so that the search for cases with the Wood's light covered a sufficient number of schools to define the epidemic area. In each school where clinical cases had been recognized, the nurse was readily trained by the dermatologist to spot the characteristic fluorescent appearance of the infected hair under the light. Even a single infected hair could be recognized after observing a few cases.

By the end of June, it was clear from the rapid inspection with the Wood's light of all the classes in the selected schools that there were six schools in one geographical area where the disease was of epidemic proportions. The number of pupils and the number of cases by schools were as follows: 100 cases among 987 pupils; 62 cases among 1,400 pupils; 27 cases among 1,400 pupils (junior high school); 20 cases among 930 pupils; 19 cases among 649 pupils; and 23 cases among 904 pupils. The latter school was in another district but in a neighborhood adjoining the first epidemic school.

By the time the epidemic incidence was recognized in this district during the Spring, a new area was discovered where 59 cases in three neighboring schools were finally identified after screening all

the classes with the Wood's light. As this second focus was more than five miles away from the original area, no connection was established. The cases were discovered because the same health officer had jurisdiction over the second area and he was aware of the problem from the experience in the first area. He had urged the medical and nursing staff to enlist the teachers' assistance in special efforts to inspect children and refer suspicious cases to the nurse. Sporadic cases were found in 10 other schools in the first district and seven more schools in the second district but these cases were not known to be associated with the two foci of infection.

NURSE-TEACHER COOPERATION

This experience with ringworm of the scalp has confirmed further the value of teacher observations and referral as a first line of defense against contagion. The first cases were discovered as a result of teacher observation and referral. More cases were found as the nurse and teacher worked together on this problem. Routine classroom inspections were made not only to check whether cases had been missed but to encourage the teachers to make further efforts and to discover cases that provided a basis for discussion of conditions that should be referred to the nurse. Both the teacher and the nurse learned from each other about the family background where there were cases. New understanding was given concerning how the disease is transmitted. The importance of family contacts was illustrated by the discovery of contact cases that were discussed with the teacher. Questions were answered concerning the reasons for the long period of treatment. The relation to the familiar ringworm of the glabrous skin was interpreted by the discovery of new

cases where there was exposure to glabrous skin cases. Many features of the disease were discussed and questions were cleared up that would not have been understood by the teachers without such case discussion. This increased understanding brought about the kind of teamwork between teacher and nurse that is essential for effective education and preventive measures for the control of any infection.

The experience thus far has seemed to indicate that when there is good teamwork, the inspection by the teacher and nurse without the lamp serves to identify the schools where the disease is most likely to be of epidemic proportions. However, it proved to be good economy to refer all suspected cases to the dermatologist with the Wood's light for confirmation of the diagnosis. This procedure provided accurate detection of cases before initiating either follow-up or a thorough search of all the classes with the Wood's light.

FOLLOW-UP SERVICE

While good case finding facilities are essential, that is only half the battle. A follow-up service that never rests until the case is free from infection demands more than ordinary skill, tact and co-operation with community resources. Many cases of X-ray epilation have been found to be unsuccessful because of insufficient dosage and a failure to cause a complete defluvium or loss of hair of the scalp. The treatment following the loss of hair often requires manual epilation under the Wood's light as the regrowth of hair begins. The follow-up after epilation then must be very active in order that any remnants of the infection may not be neglected. Before epilation the follow-up must be just as active in order that the progress of the disease may be

watched. Most of our cases sought their family physician as soon as the case was excluded from school. Others went to various hospital clinics that were not equipped with Wood's light nor facilities for mycological study. While both private practitioners and hospital dermatologists accepted readily the interpretation of this public health problem from the Medical Society and the Health Officer, the parents were usually resistant at first to the idea of X-ray epilation. They were very slow to believe or else did not comprehend the whole story that the nurse explained about the disease.

PARENT EDUCATION

The usual course was a preliminary period of ineffective treatment with topical applications and then a gradual realization by the parent that loss of school time and continued treatment was a nuisance. When the parents saw with their own eyes under the Wood's light just what progress was being made, they began to ask questions and to understand their problem. When they saw that the infected area was not decreasing in size or that it was actually spreading, they were usually ready to accept X-ray epilation. As the child rarely suffers any discomfort from the disease, the follow-up must be active and continuous to take advantage of any change of attitude of the parent. When the private physician had no Wood's light, the physician at the follow-up center offered to mark out the area of infection on the scalp. As the practitioner recognized the failure of the usual anti-fungicidal applications, he often appealed for advice regarding treatment. When the lesion was small and well localized, the suggestion was made to the physician that the parent could come to school to pluck the infected hair under the Wood's light. Such cases were

urged to continue to return to the private physician for supervision and advice regarding medication. The Medical Society furnished the list of physicians qualified as dermatologists by the Compensation Board and their cooperation was obtained. Physicians were also informed about the clinics that had satisfactory facilities. After the general practitioners had had experience with one or two cases they usually referred their cases to dermatologists or clinics. One general practitioner obtained his own Wood's light and arranged with a university hospital for X-ray epilation with very satisfactory results. In other situations the clinic or the practitioners referred the cases to the health department physician for continued observation after X-ray epilation, and in some cases it was necessary for the dermatologist of the Department of Health to take over the full responsibility for treatment at the request of the practitioner because that seemed to be the only way to get daily manual epilation and close supervision of the treatment of localized areas of the scalp.

ADEQUATE RECORD-KEEPING

The importance of adequate records of each case led to a centralization of the records in two follow-up centers located in school buildings in the two health center districts nearest the residence of most of the cases. Parents were invited to come to these follow-up centers for periodic inspection of contacts, review of progress of the disease and medical guidance. As cases were discovered which were not under treatment because of various problems in the home, it was found necessary to accept more cases for treatment in the follow-up centers. All X-ray epilation, however, was done in the offices of private dermatologists or

PUBLIC HEALTH NURSING

the few hospital clinics that were equipped for the service.

Cases not responding to a post card invitation to the follow-up center were referred to the district health department visiting nurse for home visit. The organization of the follow-up is dependent upon adequate history taking and recording of the findings at each visit to the follow-up center or proper record at the time of the home visit. Other necessary data are the date and result of examination of contacts, the visits to the treatment agency, the kind of treatment received and where, the progress of the disease as shown by repeated Wood's light examinations and the decision where further treatment is to be obtained. This decision is the result of the medical guidance given the parent at the follow-up center or in the home. Cases were directed back to their own physician or the clinic of their choice but the tendency for parents to become discouraged with the treatment or dissatisfied with the attention they received in crowded clinics raised many problems of guidance in keeping the patients under medical care.

While the infection was no doubt spread through many kinds of personal contacts in and outside of the home, the education of the parents seemed to be the only practical means of minimizing these contacts except as treatment of the known cases was carried out until free from infection. Mimeographed instructions were used to supplement the teaching of the nurse and teachers concerning the precautions that should be taken by each patient.

PHYSICIAN-PARENT RELATIONSHIPS

The follow-up center served both as a liaison with the practitioner and a guidance service to the parents. While

there was no problem of continuing treatment when the physician had the full confidence of the parent, the resistance of the infection to treatment raised a serious question of education to maintain that confidence. The most difficult problems occurred when the parents reached that stage of discouragement and lack of faith in medical service that they sought quack, pseudo-scientific, and superstitious forms of self-medication or gave up the treatment entirely. These cases made clear the importance of the relationship between the patients and their physician. To foster this relationship parents were given letters to their physician from the health department follow-up center and were told of consultations between the health department physician and their own physician. They seemed encouraged to learn that the health department staff and their physician were able to work together to control the infection. The physicians invariably accepted the health department responsibility for deciding when a case was free from infection. While some misunderstandings arose from delay in presenting to them all the facts, they gave their wholehearted cooperation when they understood the epidemic character of the problem.

GENERAL OBSERVATIONS

The experience with this epidemic has emphasized:

1. The importance of a plan for obtaining complete records.
2. Teacher observation and referral combined with frequent teacher-nurse conferences served as an effective first line of defense.
3. Accurate diagnosis with the help of the Wood's light was essential for case finding.
4. The follow-up required an unusual

RINGWORM OF THE SCALP

amount of diligence, medical advice, and understanding of the disease.

5. Extra nursing service is necessary unless the nursing staff is taken from other work to meet the needs for frequent contacts with patients, parents and treatment agencies.

6. An effective liaison with private practitioners and treatment clinics is so essential that adequate time for interviewing physicians giving the treatment should be definitely arranged.

Postgraduate Training

(Continued from page 558)

graduate nurses from other countries with American nursing methods.

Graduate nurses who wish to specialize in anesthesia or midwifery are also eligible for the federal program. Such programs may be conducted by universities, colleges, hospitals or other institutions.

Under the Bolton Act, the graduate nurse must meet the special admission and graduation requirements for a scholarship in the particular program or course she chooses. She must be physically fit and must present evidence of that fitness upon admission to the training program or course.

Before entering on postgraduate work, the nurse must present a statement to the effect that she will be available upon completion of the program or course for her choice of essential nursing service—military or other federal governmental, or civilian.

Hospitals, nursing schools, and public health nursing agencies are being urged to encourage promising members of their staffs or their new graduates to avail themselves of these postgraduate opportunities. Graduate nurses themselves are

*Ringworm of the scalp in children may be generally suspected when there are localized scaly patches; short, stumpy, broken off hairs; various degrees of inflammation. The special character of the disease is the presence of broken hairs scattered over patch-like stubble. There are several possible causative organisms in ringworm of the scalp. In a given case the organism should be identified by laboratory culture before treatment is instituted, since some types of infection are curable by one means while others may require a different method of treatment.

urged to apply for the federal scholarships.

Universities or colleges participating in the federal training of nurses program must be approved by the appropriate accrediting agency and must have a well established program meeting standards recognized or equivalent to those of the Association of Collegiate Schools of Nursing and the National League of Nursing Education. Public health nursing programs of studies must be approved by the National Organization for Public Health Nursing. Hospitals must be approved by the American College of Surgeons with American Psychiatric Association approval necessary for hospitals offering clinical courses in psychiatric nursing. Approval by the American College of Surgeons is needed for participation in programs for preparing nurse anesthetists, while approval of the Children's Bureau is required for programs in midwifery.

Combining a great wartime service with training for a promising postwar future, these postgraduate programs and courses present a challenge to the graduate nurse. They are a part of the contribution of America's nursing services to victory on the battlefield and on the home front.

A County Generalizes Orthopedics

By ANNE H. McCABE, R.N.

WHEN ORGANIZED in 1930, the Westchester County Department of Health started with specialized nurses, but by 1937 the services had become generalized with the exception of orthopedics, which functioned as a separate program until July 1941. The program ran smoothly and efficiently when the orthopedic nurse was here, but during her vacation and sick leaves, none of the nurses could relieve her. Clinics and home visits had to be suspended until her return to duty. It was even difficult to answer telephone requests intelligently which from an administrative standpoint was embarrassing. Since we are a small organization, the employment of a second orthopedic nurse was impractical, so we decided to generalize the service as far as possible.

The Division of Public Health Nursing of the New York State Department of Health was interested in having such an experiment worked out in a small unit, and as we are a subsidiary department of the State, we decided to put the plan into effect in July 1941.

Several factors favored the initiation of the project at this particular time.

1. Re-evaluation of peacetime services was essential for efficiency if medical and nursing personnel were to be curtailed due to needs of the armed forces.

2. The rationing of gasoline and tires made it urgent that one nurse carry out all the nursing services in a given area.

3. Scholarships awarded to members of the staff by the local chapter of the

National Foundation for Infantile Paralysis for study in the Kenny method for treatment of patients with infantile paralysis developed interest of the group in this phase of nursing.

4. The orthopedic nurse in the area was keenly interested in the plan.

EDUCATIONAL PROGRAM

A program of staff education preceded generalization of the service and was continued as an integral part of the plan.

In the fall semester a university extension course, "Survey of Orthopedic Defects," was conducted in the county seat, White Plains, and all eligible nurses took the course, including the orthopedic and supervising nurses. Concurrently with this course, the orthopedic nurse, Lucy Lewandowska, also a qualified physiotherapist, held regular discussions with the supervisors to familiarize them with the program. She attended the local staff conferences to acquaint herself with the general public health nursing policies. Through a grant from the Westchester Committee of the National Foundation of Infantile Paralysis, Miss Lewandowska took the Kenny course in muscle re-education at the University of Minnesota, and the five supervising nurses spent two weeks at the D. T. Watson School of Physiotherapy, University of Pittsburgh, to study the nursing aspects of the treatment. On her return from Minnesota in the summer of 1942, Miss Lewandowska organized and conducted a three-day institute in the Kenny method. This

COUNTY GENERALIZES ORTHOPEDICS

consisted of demonstrations of the nursing care and discussions on muscle re-education.

The subsequent staff education program was planned for regular periodic group conferences and these formed the basis of a manual for general use.

HOW THE PLAN WAS CARRIED OUT

Before allocating the cases, the New York State orthopedic consultant nurse, Marion Davis, was called in to assist Miss Lewandowska in reviewing the orthopedic case load which consisted of 540 cases. Of these, 305 cases were selected for distribution among the generalized staff. Each case was carefully analyzed and discussed with the nurse who was assuming responsibility for the follow-up care. The remaining 235 cases were retained by the orthopedic nurse as these required physiotherapy treatment and supervision in the home. But as soon as the mothers had mastered the daily exercises they were then to be referred to the generalized nurse. The 305 cases referred for generalization included patients with infantile paralysis, congenital deformities, scoliosis, Erbs palsy, torticollis and a variety of other conditions.

The generalized nurses assisted in the orthopedic clinics by interviewing the initial case, assisting clinician with the examination of the patient, attending parent conferences with the orthopedic nurse, attending conferences of the orthopedic nurse and physician following each clinic session where special problems seen in the clinic are discussed, making follow-up home visits.

HOW THE PLAN WORKED

The cases were transferred in March 1942, and the program has been functioning for 15 months. There is every indication that it has been a successful venture. Keen interest in the program is shown both by the orthopedic nurse and the staff. The staff has become orthopedic conscious, especially in visiting new cases, and the orthopedic nurse has a broader understanding of the general public health nursing approach to the family. The nurses are detecting early symptoms, especially in newborn and young children. Five patients with orthopedic defects have been discovered by the generalized nurse in giving the demonstration bath. With the help of the orthopedic consultant nurse the generalized nurse assisted the families to secure corrective care under the direction of a qualified orthopedic surgeon. Had these patients not been brought to medical attention early a much longer period of time might have been required for correction.

Generalization of the orthopedic service has been a most interesting venture, and its success is equally due to Miss Lewandowska, the orthopedic nurse who firmly believed it was a practical and workable program and the staff nurses who have spent additional time in study. The orthopedic program can be generalized, but requires the assistance of a specialized consultant. Concentrated study and preparation of the general staff is essential to keep the program functioning at an efficient level.

THE NEW ENGLAND Division of the American Association of Industrial Nurses will hold its 28th annual meeting at the Hotel Statler, Boston, on October 23 and 24. Besides business meetings, the program includes a dinner on October 23 with Everett King of Lever Brothers, J. J. Bloomfield of USPHS, and T. O. Armstrong of Westinghouse Electric as speakers; and a breakfast October 24 at which Janet M. Geister, editor of *Trained Nurse and Hospital Review*, is the featured speaker.



Detroit V. N. A.

Positions to prevent deformities of patient with cerebral accident showing support for foot and arm

Orthopedics in a City Nursing Program

By LOUISE M. SUCHOMEL, R.N.

A WELL-PREPARED public health nurse must have an understanding of orthopedics and an awareness of the potential orthopedic patient in order to make her fullest contribution in a complete public health program. Many public health nurses have not had contact with orthopedic patients in years and have not had the opportunity to follow a patient's recovery through his long period of treatment and rehabilitation.

The nurse makes her greatest contribution to the orthopedic program in case finding, prevention of orthopedic conditions, and in giving care to the orthopedic and potential orthopedic patient.

The Detroit Visiting Nurse Association has endeavored to develop staff interest in orthopedics; to help the staff nurse appreciate orthopedic implications in all her nursing services; to prepare the nurse to prevent, recognize, and anticipate conditions causing or predisposing to ortho-

pedic conditions; and to give the nurse an opportunity to put into practice some of the techniques of physical therapy as applied to the patient in the home.

A series of orthopedic conferences was given in each of our Visiting Nurse Association substations by the orthopedic field supervisor. The current case load was studied by the substation supervisor and the orthopedic supervisor for patients who presented orthopedic problems. The orthopedic supervisor, or the staff physical therapist serving as orthopedic consultant in that area, arranged office conferences and home visits with the general district nurse when indicated.

Material presented in the group conferences included:

1. Correlation of orthopedics in a generalized program.
2. Importance of the examination of the newborn.
3. Body mechanics and functional anatomy and their application for the prevention of

ORTHOPEDICS IN CITY PROGRAM

orthopedic conditions and the promotion of good general health.

4. Posture of the body in rest and activity, including demonstration of devices for maintaining orthopedic correction.

5. Massage theory and practice.

6. Demonstration of therapeutic exercises and discussion of purpose and value in care of cerebral accident, arthritis, fractures, birth injuries, congenital deformities and poliomyelitis patients. The pathology, symptoms, and most recommended treatment programs for conditions listed above were discussed. Emphasis was placed on the group's present needs.

The Detroit VNA offers service to patients with orthopedic conditions either in their homes or in a curative workshop. Ambulatory patients come to the workshop where both physical therapy and occupational therapy are available upon prescription of the physician. The staff of the workshop includes a director who is a qualified physical therapist, and an occupational therapist. The service in the homes is given or supervised by a staff of six nurses including a supervisor, all qualified in physical therapy. These specialized nurses give direct service to some patients and act as consultants on orthopedic problems to the general nurses.

Each physical therapist visits the substations in her district—usually two or three—on two mornings per week to help the nurses with individual problems through conferences and to arrange home visits with the nurses to demonstrate desirable positions in bed and to demonstrate or supervise physical therapy treatments. The physical therapist evaluates the patients' needs and, with approval of the physician, selects the patients to whom the general staff nurse may give the treatment with her guidance.

The patient's needs, the extent and severity of his injury and the availability of a member of the family to give supple-

mentary care are factors to be considered in the selection of patients who may be carried by the general nurse.

General nurses have given excellent care to many cerebral accident patients. Whenever possible the nurse instructs a member of the family to give care between her visits. This cannot always be done since frequently small children may be left to care for a helpless grandparent during the absence of parents who are employed in war industries. In such instances daily visits by the nurse may be necessary. Just as soon as the patient's condition permits he is transferred to the curative workshop.

Young inexperienced mothers often feel their inadequacy in giving exercises to a child with a mild club foot or torticollis. The general nurse, with a demonstration and occasional supervision by the physical therapist, can assume responsibility for teaching these mothers.

During the early care of fractures, nurses can prevent additional deformity by preventing contractures of adjacent joints such as flexion contractures of knees in a Potts fracture, or contractures of the shoulder adductors and elbow flexors when the patient has a Colles' fracture.

A recent evaluation study of our program shows a continued increase in the number of patients referred by general nurses for consultation or supervision of care. This indicates the awareness our general staff has of orthopedic and potential orthopedic patients. With a generalized program, far more patients have received the much needed early orthopedic care which has prevented permanent deformities, lessened the period of treatment, and the cost of care for the family and the community.

Comments on "Generalizing Orthopedics"

THE ATTEMPTS to generalize orthopedic services in public health nursing agencies which have been described by Mrs. McCabe and Miss Suchomel show certain similarities in program and methods.

1. In each instance the service given includes nursing and physical therapy.

2. In each agency the consultant nurse is also qualified in physical therapy.

3. An intensive program of staff education in orthopedics preceded the generalization of the services and was continued to keep the service functioning effectively.

4. Patients who were transferred to the general nurse were carefully selected and the nurse was given guidance in regard to the responsibilities involved in home care, treatment, and supervision.

5. In neither instances were the orthopedic services completely generalized. Some patients requiring the treatment service were carried by the nurse qualified in physical therapy either on a temporary or continued basis.

For a long time it has been recognized that there is need for clarifying terminology used in relation to orthopedic programs in public health nursing agencies. The terms *orthopedic nursing*, *physical therapy*, and *orthopedic nurse* are not clearly understood. The term *orthopedic nursing* has been confusing especially in the public health field since it has sometimes been used to include physical therapy services. In the hospital, *orthopedic nursing* is used to indicate the nursing care of patients with orthopedic conditions. Its use is comparable to pediatric nursing, or psychiatric nursing. In one sense it is a separate entity since special knowledge and skills are required for care of patients in traction, casts or other appliances. In a broader sense it should also mean the practical application of the principles of body mechanics and posture to all nursing care and health supervision. The orthopedic content in all nursing should include early recognition and prevention of potential orthopedic disabilities. Physical therapy on the other hand is largely a treatment service. Nursing services in orthopedic programs in public health nursing agencies can be effectively carried out by the general staff nurse. Physical therapy treatments for patients with all types of orthopedic conditions, however, cannot routinely be assigned to the nurse who has not had special training in this field. Never-

theless, since physical therapy technicians have long taught certain procedures to parents it is only logical to expect that comparable and additional responsibilities may be shared with general staff nurses. These two articles show how such a plan can be made workable through staff education, selection of patients, and continued supervision.

Use of the term *orthopedic nurse* to indicate the person who is also responsible for physical therapy procedures in a public health nursing agency doubtless developed because the same person frequently is responsible for both services. For example, Mrs. McCabe refers to the specialized consultant as the *orthopedic nurse* while Miss Suchomel refers to her as a *physical therapist*. One suggestion for clarification is that the public health nursing agency designate its program as an orthopedic service and its specialized supervisor or consultant as orthopedic supervisor or consultant. This terminology is broad enough to include either nursing or physical therapy or both. The letters "R.N., R.P.T.T." after the nurse's name could be used, if desired, to indicate that she is both a registered nurse and a registered physical therapy technician.

Other agencies which are attempting to generalize part of their orthopedic service would be helped by further discussion of the factors which should influence the selection of patients who are transferred to general nurses for treatment services. Illustrations of patients whose conditions may require that the staff member qualified in physical therapy initiate the treatment or continue it are poliomyelitis patients of recent onset who require muscle re-education, complicated fracture patients, patients with peripheral nerve injuries, or patients with painful joints or muscles in spasm. In other words, the condition of the joints and muscles rather than the diagnosis should be a major consideration in determining the basis of selection.

Orthopedic consultants in public health nursing agencies would also be interested in further discussion of the content and method of staff education which will enable the general nurse to assume with confidence additional responsibilities in the care of patients with orthopedic conditions.

JESSIE L. STEVENSON, R.N.
CONSULTANT IN ORTHOPEDIC NURSING

Counselling by Correspondence

By GENEVA M. THEIS, R.N.

ONE of the most difficult things to do in rural areas in this wartime emergency is to secure well qualified and properly prepared supervisors. A second problem is to cope with tire and gas rationing and with inadequate train and bus facilities. Many county public health nurses whose districts extend over vast and sparsely populated areas look to their supervisor for advice on difficult problems. Because of travel difficulties, the supervisor is unable to make frequent visits to help them. Necessity has prompted the development of many devices to handle supervision problems by remote control—the official agency bulletin, the newsletter, and counselling by correspondence.

The agency bulletin is usually sent to all of the nursing staff—its purpose not to give individual supervision but rather to facilitate group thinking. Newsletters contain material of a more chatty or social nature but, like the bulletin, have a general circulation. The third method is counselling by correspondence—a partial substitute for the infrequent personal conference.

Personal interviews and conferences are necessary to bring about a closer relationship and understanding between supervisor and field nurse and a greater interest and cooperation in the work which is being done. Supervision by correspondence has been carried on by supervisors for many years although they were perhaps not conscious of it. As the

war continues and the shortages and emergencies become greater, the need for this means of exchange of ideas will be more frequent.

Many of the same methods may be employed in a letter as in a personal interview and perhaps the same results obtained. But if correspondence is going to be the method of communication, the mechanics of letter writing should be well known. Many pointers for the construction of a good letter can be obtained from an up-to-date manual of style or business secretary's handbook and such a manual is a necessary item on every supervisor's bookshelf.

These rules are basic. A letter should attract attention and arouse interest, state its purpose clearly, contain reference to previous correspondence, give all facts simply, and, finally, give clear decisions or directions. It is particularly important that the opening of the letter impress and interest the recipient. Perhaps a chatty remark or reference to some talent or asset of the individual will do the trick. The closing sentence should be a clinching statement, made direct. S. R. Stauffer in *Letters, the Wings of Business* says, "According to psychological tests, the first and last impressions are more effective than those received in between. The beginning and end of letters should be mental expressions that arrest favorable attention and secure definite and positive reactions."

The supervisor will have to go even

further than the business man in her planning of a letter. She must visualize the personality of the nurse, conditions under which she is working, and the problems which have been presented by her. She must recognize the preparation the nurse may have had for this type of supervision and her reaction to it. She must understand what advantages are gained by both the agency and the nurse. She must know the details about the community in which the nurse is working.

BUT FIRST the supervisor will need to do a bit of self-analysis. If she is capable of answering the following questions honestly in her mind, the intended letter will the more likely have the desired effect.

Am I physically and emotionally in good condition?

Am I prepared to give information and insight on the problem?

Do I have sufficient accurate knowledge about the nurse's problems?

Have I tried to see the nurse's point of view?

Am I using an approach that I would like were I in her place?

Am I consciously shifting the initiative in solving the problem from myself to the nurse?

Is my attitude free from bias?

Am I being sincere in what I write and am I genuinely interested in the nurse?

One of the most damaging things a supervisor can ever do to herself, her agency and the staff nurse, is to write a letter in a "fit of anger." If she has transferred such a mood to paper, no matter how sane she thinks it sounds at the time, it is best that she refrain from mailing it until she has "cooled off" and re-read it. She will probably find that she wants to rewrite it.

Next the supervisor will want to be sure of her understanding of the nurse to be counselled and her situation. The supervisor needs to establish a friendly relationship with the nurse, encourage

and guide her in planning for the future and evaluating the past, seek to understand the particular personality and recognize her potentialities, and, lastly, safeguard the services of the organization in which she works.

The supervisor can secure some of her data about the nurse in question by a careful study of her monthly reports and records, by reviewing previous letters and any analysis of her work which may be on file. Often the supervisor may find she can get practically the same results by inspection of records sent her by mail as by a personal visit to the nurse's office.

Reports and records more than anything else reflect the nurse's immediate behavior, needs and abilities as well as her developmental trends. Through them the supervisor can make her acquaintance and help her in self-diagnosis. They show also whether the program is functioning and whether the nurse is planning her work carefully. They provide a means for recording the results of accomplishments.

There is, of course, in supervision by correspondence, danger that the field nurse may send the supervisor only her best records. This could happen, however, even if the supervisor made a personal trip to the agency. The cost of mailing records is another disadvantage, also the possibility of their being lost unless insured or registered, and the element of time involved. Furthermore, the supervisor can only suggest and not inspect when it comes to filing.

However, supervising records by correspondence saves time, travel, and money. This system may even stimulate better record keeping and filing. It gives the nurse greater initiative. She knows that the supervisor at a distance will be outside the situation and will want clear and concise statements and comprehensive data before she can render a decision by letter.

THE SUPERVISOR can evaluate the work of the field nurse through her monthly and annual reports. These reports contain statistical data which is to be used by the state department of health and USPHS in turn. They give the supervisor a fairly adequate idea of how the work is divided and whether or not the nurse is placing too much emphasis on one certain service and neglecting another. The supervisor can use the reports for comparative purposes and for the evaluation of the growth of the work, perhaps under successive nurses.

For example, the supervisor, provided she has adequate census data at hand, can determine the proportion of the population protected against smallpox and diphtheria, the proportion of the newborn taken care of by the individual public health nurse. By this means the nurse has been getting at the root of problems in preventive medicine.

Another illustration. The supervisor can play an important part in the sound establishment and use of clinics by means of correspondence. Of course, their establishment will depend entirely on the attitude of the medical profession, the need in the community, the funds available, the demand from the public, and the field nurse's and health officer's attitude or enthusiasm. The supervisor's letters can offer considerable assistance or advice in the determination of certain policies, equipment and supplies, types of records and reports to be kept, budget, the kind of care to be given by the nurse, the kind of literature to be given out for the purpose of publicity and instruction, the frequency of the clinic, the use of volunteer workers, and the manual of techniques which is to be used. The supervisor can judge the amount of service rendered, number of cases seen and the results obtained, by the monthly report and the records. But she cannot

judge the working mechanics or quality of the techniques used except by a personal visit.

The supervisor can help the nurse in planning a suitable library. She can suggest the books and periodicals which will be of the greatest benefit and keep the nurse posted on new and authoritative literature in the state health department library.

Time studies and graphs are still other media for supervision. The time study is not always an accurate vehicle for determining whether or not the nurse is wasting her time or using it advantageously, but it gives the nurse herself and the supervisor a fairly good idea as to how the time is being spent in the field. Much of this, of course, will depend on the extent of the area to be covered, its topography, the condition of roads, climatic conditions, the population whether scattered or centrally located, the type of calls to be made, and the class of people to be served. The graph can be a good index of how certain kinds of services are being distributed in a given area. Both the graph and time study can be sent by mail to the supervisor for further study.

The supervisor can in her letters stimulate interest in further education by suggesting schools offering a program of study in public health nursing which has been approved by the NOPHN. Institutes, refresher courses, public health meetings, and district meetings offer an opportunity to meet people in the field, make friendly associations, and discuss many common problems both in a formal and informal manner. Interests of the individual nurse and her developmental and professional growth are reflected in her reports of attendance at these various functions and her desire to further her education.

From these comments and suggestions

PUBLIC HEALTH NURSING

it can readily be seen that the records, monthly and annual reports, graphs, and time studies are important means by which supervision can be carried on through correspondence.

The nurse may also ask by letter for suggestions and advice in regard to specific problems. In replying, the supervisor

must ever keep in mind that the initiative should be taken and held by the nurse herself at every possible opportunity. Nor should she forget there is danger in resorting to this type of supervision too much and neglect her responsibility of making field visits. Letters can never entirely replace personal visits.

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POOLING COMMUNITY NURSING RESOURCES

The following resolution was passed by the Committee on Nursing Administration of the NOPHN on March 5, 1943, and sent to the Federal Office of Education, the American Association of School Administrators, and to the state departments of education. Many of the latter secured enough copies to send to all of the local school administrators in their respective states.

WHEREAS, The greatly increased need for nurses for the armed forces and for industrial establishments has necessarily reduced the number available for community nursing services for the civilian population, and

WHEREAS, Only the most essential civilian services can hence be maintained under conditions of strictest economy of personnel and facilities, and

WHEREAS, Such economies can be achieved only through the thorough co-

ordination of community nursing services, including pooling of all available nursing personnel, and

WHEREAS, Public health authorities, departments of health, and other health agencies are urging and supporting the coordination of community services, and

WHEREAS, Departments of education are involved in the administration of nursing services in that they employ school nurses directly in many communities throughout the country.

BE IT RESOLVED, That the National Organization for Public Health Nursing, through its Committee on Nursing Administration, urges the U. S. Office of Education to bring to the attention of state and local departments of education the importance of participating in the coordination of local community nursing services, including the pooling of nursing personnel.

An Effective Use of On-Call Time

BY ELIZABETH BURNETT, R.N.

THE VALUE of home delivery nursing service to both patients and doctors needs no discussion. In this country providing intrapartum nursing service is now accepted as a responsibility by those directly concerned with the care of mothers who must still be delivered at home. There are two distinct areas in which the provision of a home delivery service is a pressing problem—the rural area which has as yet no hospital facilities, and the defense centers like Detroit whose population has increased because of the war but whose hospital facilities have remained approximately the same. In metropolitan Detroit the delivery service offered by the Visiting Nurse Association has doubled in the past year because hospital facilities are too limited to meet the demands of an increased population and a rising birth rate.

The actual providing of home delivery service presents many problems of administration, only two of which and one method for meeting them will be discussed here. These two problems are (1) the effective use of "on-call" time of night nurses and (2) the necessity for giving an intensive review to the public health nurse who has not been doing intrapartum nursing for some time.

After eight months of trial, the plan developed by the Detroit Visiting Nurse Association of having evening and night delivery nurses "on call" in a hospital has proved more successful than was ever

hoped when the plan was first considered and later put into practice.

From October 1942 to June 1943, the average number of intrapartum calls per month was 177. For the same months of previous years the number was 83. Service is provided to patients of private physicians on a cost, part cost and free basis; and to patients cared for by City Physicians through a contract on a full-fee basis. About one fourth of the total number of patients are those of City Physicians. The area covered by the delivery service is approximately 500 square miles.

A staff of 11 nurses on an 8-hour day and a 5½-day week is required to cover this 24-hour day, 7-day week service. In each 24-hour period, "waiting time" accounts for slightly less than one half the total period. The delivery service staff, except for the assistant and two others whose special interest is intrapartum nursing, is a rotating one. This in itself presents an administrative problem because of constant change, and an educational problem because of the uneven preparation of nurses in obstetric nursing. The chief justification for a rotating delivery staff in a public health nursing organization is the vast improvement observed in antepartum and postpartum service after the nurse returns to the general staff. The delivery nursing experience helps, as no other service can, to crystallize and keep in focus the interrelationship of the health of the mother

PUBLIC HEALTH NURSING

in the antepartum, intrapartum and postpartum periods—an all-important fundamental for any public health nurse working with maternity patients.

Until the "on call in the hospital" plan was initiated, nurses had remained at home while on call. This presented a problem of travel, both time and cost, since nurses live in all areas of the city—usually in areas with few delivery calls. Then, too, some nurses live in residence halls where no night telephone service is available, which means that these nurses cannot be assigned to delivery service. Taking over the City Physician service brought a concentration of calls in the central area of the city.

The problem of giving the nurses an intensive review in obstetrical nursing is a real one, and of necessity has to be done almost entirely on an individual teaching basis. A pre-test is given when the nurse first comes to delivery service which may reveal that some procedures are entirely new to her. Taking fetal heart tones is an example of a procedure usually unfamiliar to all but rather recent graduates. Giving intravenous drugs at delivery is also new to most public health nurses. A comprehensive knowledge of obstetric terminology is important, for too often the nurse knows only the terms used in her own hospital. For instance, some physicians describe the progress of labor by "stations," rather than by dilatation alone. Since 450 different private physicians used the delivery service of the Detroit Visiting Nurse Association last year, the delivery nurse really needs to be well versed in obstetric language.

The plan of stationing the nurses on call in a hospital seemed to be a way of meeting three needs—for a central "on-call" place, an effective use of the nurse's "on-call" time, and a quicker brush-up on delivery nursing than can be provided

on an individual home teaching basis. We were fortunate in having a good working relationship with Woman's Hospital. This is a centrally located Detroit hospital with an intensive teaching program for residents, internes, medical students, postgraduate and undergraduate affiliating nurses. The total number of deliveries there for 1942 was 3,360. In past years we had sold this hospital the time of a visiting nurse to teach a class of antepartum clinic patients. Postgraduate and undergraduate affiliating students had come to a home delivery demonstration at the Visiting Nurse Association Teaching Center. (Postgraduate students now observe a home delivery on request.) We felt sure that the administrative staff would be interested in our plan because the superintendent of the hospital and the director of nursing are graduate midwives, and the assistant director and educational director have both had public health nursing experience. Their feeling for the maternity patient in the home is still a real one. The plan was accepted at once.

Several conferences were held with the home delivery staff. In selling the plan we appealed to three all-important assets of any good delivery nurse—a pioneering spirit, above-average adaptability and a willingness to experiment. The staff deserves much credit for their readiness to participate.

Our request that our nurses work entirely in the birthrooms or nurseries was granted since that would be the most valuable learning experience. However, if the postpartum floor is unusually busy, they may be assigned there temporarily even though visiting nurses are familiar with postpartum care. Following are the "Instructions" for the plan as it operates now. Since this was an experiment, changes are made as need is indicated.

USE OF ON-CALL TIME

VISITING NURSE ASSOCIATION—DETROIT

Instructions for Delivery Nurses Working "On Call" in Woman's Hospital

1. Nurses on the 3 p. m. to 11 p. m. schedule report at Woman's Hospital between 5 p. m. and 6 p. m. depending on the time of completing, and location of, the last field call. Nurses on 11 p. m. to 7 a. m. schedule report at 11 p. m.

2. On entering the hospital nurses sign name and time of arrival in "Time Book for Home Delivery Nurses" which is kept at the switchboard, and sign out when going off duty, or when leaving for a delivery.

3. Calls for home deliveries are received by the nurse direct from the Registrar of the Nursing Bureau.

4. Nurses report to the Birthroom Head Nurse for assignment. When re-assigned to the Nursery or Postpartum floors, nurses fill out slip with date, name, and hours of service, and leave this slip on 5-East desk for the Birthroom Supervisor.

5. A report of Birthroom and Nursery experience (on form provided) is kept by the nurse, checked by Birthroom and Nursery Supervisor, is signed by the nurse and supervisor, and given to the Maternity Service Supervisor of the Visiting Nurse Association.

(This experience report is necessary both to help the nurse secure the desired experience and to enable her to give more efficient service to the hospital. A Visiting Nurse is not expected to do any procedure or treatment unfamiliar to her until a demonstration has been given and supervised by the head nurse. Visiting Nurses read Birthroom, Nursery, and Postpartum floor procedures before coming "on call" in the hospital.)

6. Nurses rotate service in Birthrooms and Nurseries until the individual experience reports are completed. Then an optional service may be granted with permission of the Nursing Director of the Hospital and the Maternity Service Supervisor of the Visiting Nurse Association.

7. White uniforms are provided by the Visiting Nurse Association and are kept in 5-East Lockers. The hospital launders these uniforms.

8. One meal during each 8-hour schedule is given by the hospital. Meal tickets are obtained from the Nursing Office.

9. Nurses remain on duty at the hospital until 11 p. m. and 7 a. m. Nurses return to the hospital on completing a delivery call if one hour or longer would be spent in the hospital before the regular hour of going off duty. The registrar must be notified if the nurse goes directly home from a call.

After an experimental period of two months a definite plan of experience for home delivery nurses was developed (see note under 5 above). The delivery

nurses themselves were requested to make suggestions, since sufficient time had elapsed for them to decide what had been the most valuable experience for them and, consequently, for the groups of nurses who were to succeed them. The hospital assumed a definite responsibility for the teaching and supervision of the home delivery nurses. At its request, the procedure "scrub for delivery" was included as a part of required experience, because having visiting nurses trained to scrub was of great help in rush periods. At first the delivery nurses were not enthusiastic about the latter idea, but they later decided that as scrub nurses they really do have a box seat and can observe a normal delivery without the distractions circulating nurses have. See the Birthroom and Nursery Experience Report illustrated.

If one experience can be selected as the most valuable, it is the individual help the nurses have received from the anesthetists with ether and chloroform anesthesia. Of all the unfamiliar things that the new delivery nurse must learn, anesthesia is perhaps the most frightening, and justifiably so. The anesthetists at Woman's Hospital have surely made a direct contribution to better care for mothers delivered at home through the time they have so willingly spent with the visiting nurses at the Hospital. Nurses observe three anesthetics and then give three under supervision.

Comments of the delivery nurses are revealing and interesting:

Hospital floors are just as hard and long as they ever were.

It seems wonderful to have a resident with whom to discuss difficult cases.

There is so little time in the hospital to consider the patient as an individual, since we are watching several in labor instead of doing private duty with one as we do on a home delivery.

All this sterile equipment is wonderful and necessary, but it takes away all the fun and the

PUBLIC HEALTH NURSING

WOMAN'S HOSPITAL - VISITING NURSE ASSOCIATION

BIRTHROOM AND NURSERY EXPERIENCE REPORT FOR HOME DELIVERY NURSES OF VISITING NURSE ASSOCIATION

	Instructed by	Date	Supervised by	Date	Date done by nurse	Date done by nurse	Date done by nurse	Date done by nurse
Starting Date:								
Admitting Patient								
Taking blood for Kahn Test								
Care of Patient in Labor								
Taking Fetal Heart Tones								
Taking Blood Pressure								
Report to Dr. on Pt. in Labor								
Scrub for Delivery								
Treatment of Eyes								
Care of Cord								
Giving Intravenous Drugs								
Giving Ether Anesthesia								
Care of Pt. after Delivery								
Resuscitation of Newborn								

NURSERY EXPERIENCE GUIDE

	Instructed by	Date	Supervised by	Date	Date done by nurse	Date done by nurse	Date done by nurse	Date done by nurse
Admission Bath								
Daily Bath								
Care of Cord								
Care of Circumcision								
Weighing								
Use of Light Cradle								
Taking Baby for Breast Feeding								
Care of Eyes								
Postural Drainage								

Enter on back of this sheet experience or observations not listed above, such as:

1. Breech or other abnormal deliveries, care of toxic patients, transfusions, et cetera.
2. Care of babies with complications - cord hemorrhage, excess mucus; giving oxygen, special treatments, et cetera.
3. Postpartum experience or observations.

Signature of Supervisor _____ Signature of Nurse _____
 Birthroom _____ Date of completion of experience listed above _____
 Nursery _____

sense of accomplishment we have on a home delivery in making a satisfactory and safe set-up out of almost nothing.

I certainly don't think much of this continual uniform-changing business when I come into the hospital and when I leave, but I know it is necessary.

The large turn-over of patients in the hospital gives a quick brush-up in the observation and care of both the normal and abnormal case.

You ought to hear the questions the hospital nurses ask me about public health nursing! They think we have to be very smart to be labor and birthroom nurse, doctor's assistant, anesthetist, nursery nurse and postpartum floor nurse all in one—and to find our way around at night.

We are lucky as public health nurses to be hearing and seeing the latest on the R.H. factor (Fetal Erythroblastosis) and caudal anesthesia.

If this plan of having delivery nurses on call in a hospital were to be put in operation elsewhere, experience has shown

that the following changes, or additions, would be desirable for both the visiting nurse association and the hospital. From the point of view of the visiting nurse association, it would be an advantage to assign to the first group only those already interested in hospital experience, rather than attempt to induct the whole delivery staff. It would also be advantageous to work out some plan whereby not only the administrative staff of the hospital but also the entire professional staff would understand who the visiting nurses are, what their qualifications are and what they do in the hospital. Such a plan would avoid some small misunderstandings, especially among the medical students and staff nurses. This is most

USE OF ON-CALL TIME

difficult to accomplish under present circumstances, because the shortage of nurses, pressure of work and changing personnel make general staff meetings in hospitals impracticable. It is also desirable to hold group conferences rather than individual conferences between the hospital administrative staff and the maternity supervisor of the visiting nurse association.

From the hospital point of view, it would be desirable if delivery nurses soon to be assigned would attend hospital classes and so make it possible for the hospital to reduce the amount of individual teaching time required of its staff. This is difficult for the visiting nurse association to accomplish, however, because the staff is so busy during the day when classes are scheduled, or because the night or afternoon nurses are having time off on class days. It would help if a resumé of the nurse's previous experience could be sent to the hospital before she reports there the first time. It would further contribute to a better hospital comprehension of the public health delivery nurse's work if a hospital supervisor who has had no experience in the home could observe a home delivery.

The success of such an experiment in the last analysis depends upon the understanding and good relationship between the staff nurses of both services. Credit for its amazingly smooth functioning in

this instance goes to the staffs of Woman's Hospital and the Visiting Nurse Association.

The plan has been of benefit to all concerned. The individual visiting nurse has learned much, therefore patients have benefited. The Visiting Nurse Association has profited greatly by the concentration of afternoon and night nurses "on call" in a central place because travel costs and time have been reduced. The hospital has had many hours of service by well-trained, experienced, graduate nurses at a time when its nursing staff is greatly depleted. Indirectly, hospital nurses have developed a new interest in the care and needs of the maternity patient in the home. "I don't know what we would do without the visiting nurses," the director of nurses recently said.

As the plan swung into motion we who are responsible for the home delivery nursing service felt an occasional qualm that delivery nurses might not be so keen on leaving the shining whiteness and taken-for-granted conveniences of the hospital to answer a home delivery call with all its uncertainties and responsibilities. This fear has never been justified. This was well illustrated recently when the home delivery supervisor praised a delivery nurse for her flawless performance as a "scrub-nurse." "Thanks," replied the nurse, "but I would rather help with ten home deliveries any day."

THE AMERICAN JOURNAL OF NURSING FOR OCTOBER

Genital Cancer, William F. Mengert, M.D.

Nutrition and Healthy Longevity, J. Ernestine Becker

Eleventh Evacuation Hospital in Sicily, Raymond Scott, M.C., U.S.A.

Their Mothers Are Nurses, Pearl Peabody, R.N.
Preventing Backstrain in Nursing, Kathleen Newton, R.N.

The Production Front in Nursing, Lucile Petry, R.N.

"Refreshing" Is Fun, Hazel Boyd Carnaby, R.N.

The Nurse-Midwife Is Here to Stay, Hattie Hemschemeyer, R.N.

Can Drop Outs Be Salvaged? Kathleen Leahy, R.N.

We Couldn't Do Without Aides, Dorothy Deming, R.N.

The Anecdotal Behavior Record, Wenona Abbott, R.N., Grace Reid, R.N., and Leo F. Smith

Guidance and the Faculty, Alice E. Ingmire, R.N.

Consultant Service to Industrial Nurses in Michigan

By MARY ALTON, R.N.

SIXTY-NINE of Michigan's 83 counties now have the services of local full-time health departments. The highly industrialized areas are concentrated in and around the cities in the southern half of the state.

The Bureau of Public Health Nursing of the Michigan Department of Health was organized in 1938. The following year plans were made for an industrial nursing consultant, but it was April 1941 before it was possible to carry them out. The industrial nursing consultant is one of seven consultants in the Bureau, five of whom are assigned to regional areas where they serve in a generalized advisory capacity and also carry the responsibility for one of the public health nurse specialties.

The Bureau of Industrial Hygiene is composed of the central unit located in Lansing and five district units with headquarters located in the city health departments of Grand Rapids, Saginaw, Pontiac, Kalamazoo, and the Washtenaw county health department in Ann Arbor. Each district is staffed by a trained and experienced industrial engineer who offers direct service to the plants and cooperates with local health department personnel and others concerned with industrial health problems. The central unit is headquarters for the medical director of the Bureau, an industrial hygiene physician, a chief engineer, three industrial hygiene engineers and an industrial hy-

giene chemist. This unit, in addition to all administrative functions, furnishes professional, technical and material assistance to the district units and provides a complete service to industry in all areas not covered by the district units.

The industrial nursing consultant is on the staff of the Bureau of Public Health Nursing, but she works with the personnel of the Bureau of Industrial Hygiene on a program planned cooperatively by the two bureaus. The industrial nursing consultant maintains headquarters in Lansing and covers the state, working very closely with the industrial hygiene engineers of the central and the district offices.

The first problem confronting the industrial nursing consultant was to find out the number and location of the industrial nurses in the state. A survey in 1941 revealed 353 nurses employed in 142 plants. At present the number exceeds 1,000. With this large group of nurses it is not possible to give individual supervision to all. Group supervision through the industrial nurses' clubs, the industrial nursing committees of the State Organization for Public Health Nursing and local public health groups is the chief channel of assistance.

ORGANIZATION of industrial nurses' clubs in the state has been encouraged by the consultant and in some areas assistance was given the nurses in plan-

INDUSTRIAL CONSULTANT SERVICE

ning such clubs. One club has been organized for many years. The other six clubs in the state have organized more recently either as sections of their district nurses' associations, divisions of the local safety councils or as social clubs. Meeting with the clubs is an excellent way for the consultant to discuss current problems with the industrial nurses. When a kerato-conjunctivitis epidemic seemed imminent in the state, information regarding this contagious disease was sent to several of the clubs and thereby reached a great number of industrial nurses very quickly.

The industrial nurses' committee of the State Organization for Public Health Nursing was very active in the last two years and was composed of 15 members from representative areas in the state. The industrial nursing consultant was chairman of this committee for one year. In May 1943 the industrial nurses voted to become a section of the State Nurses Association.

In June 1942 a survey of all industries in a southern county was made by the field personnel of the Bureau of Industrial Hygiene. During the week the survey was made, the industrial nursing consultant and the chief engineer held conferences with the staff of the local county health department and discussed industrial nursing and industrial hygiene programs. The local staff nurses were taken into the plants to meet the industrial nurses and to observe the industrial engineers as they carried on the survey. A demonstration of field equipment was set up in the health department office and its use explained. Since that time, the industrial nurses and the health department staff nurses have held joint monthly meetings in the health department offices. Requests were received from this group for planned observation visits to industries

employing industrial nurses. Such visits were arranged by the consultant.

At the monthly meetings of the group, such subjects have been discussed as shortage of physicians in the area, standing orders, working relationships between nurse and employer, health records, physical examination, nutrition, home visiting, individual teaching on the part of the nurse, specific health hazards, and ways the local health department can serve industry.

Discussion was augmented by material included in the industrial nursing loan folders which were prepared by the industrial nursing consultant. The folders contain material of special interest to industrial nurses in Michigan, such as reprints from recent books and magazines, pamphlets on health subjects, posters and Michigan labor and compensation laws. They have been widely circulated and have been very helpful to the many nurses who have recently entered the field of industrial nursing.

SINCE the industrial nursing consultant service was inaugurated in 1941, many visits have been made to industrial nurses on the job. Most of them seem eager for help and ask for an early return visit. Emphasis has been placed on visits to plants where nursing service has been recently added or to the small plant where the nurse is working alone and requests assistance in these visits.

Many large plants are now being completed and new medical programs planned. Graduate nurses are assisted by partially trained helpers, or first aiders working under supervision. Many small plants in the rural areas have expanded and have employed nurses to set up nursing programs. Part-time service in industry has developed rapidly in Michigan in the past two years. At the present time, two visit-

PUBLIC HEALTH NURSING

ing nurse organizations are offering this type of service.

In visits to plants having full- or part-time nursing service (especially if there is a new nurse), the consultant:

1. Helps to develop an awareness of health hazards in manufacturing processes.
2. Encourages plant surveys to learn about such items as plant housekeeping, and other environmental conditions.
3. Encourages addition of professional books and magazines to plant library.
4. Encourages use of individual conferences with employees relative to personal and family health practices.
5. Assists in development of the follow-up service through home visits, using local public health facilities.
6. Recommends acceptable industrial nursing procedures, such as standing orders, complete records, adequate space and good working environment.

The industrial nursing consultant makes visits to industries not having nursing services to:

1. Discuss the need for full- or part-time nursing service.
2. Advise regarding desirable quarters and equipment.
3. Advise regarding development of a general health program.
4. Advise regarding nursing personnel problems such as salaries, supervision, and others.
5. Assist by referring nurses.

Two industrial hygiene institutes were held by the personnel of the Bureau of Industrial Hygiene for industrial nurses and public health nurses during 1942. They consisted of a series of six classes including the medical and engineering aspects of industrial hygiene; industrial hygiene surveys and studies; industrial hazards such as dust, gas, fumes, vapors; industrial hygiene laboratory methods; and industrial nursing. It is planned to use the facilities of the Michigan Department of Health for one- or two-week institutes for nurses interested in preparation for employment in industry.

NURSE PLACEMENT SERVICE

N.P.S. announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom consent to publish these has been secured in each case from both nurse and employer.

PLACEMENTS

- *Catherine M. McDermott, director of public health nursing program of study, Duquesne University, Pittsburgh, Pa.
- *Mrs. Georgianna Gifford, coordinator of public health nursing in basic curriculum of Blodgett Hospital School of Nursing in cooperation with Community Health Service, Grand Rapids, Mich.
- *Margaret Stirling, school nurse and instructor in high school for home hygiene and care of the sick, School District No. 1, Pueblo, Colo.

Mrs. Nellie Walker, public health nurse, City Schools, Bloomington, Ill.

- *Margaret Adair, staff nurse, Visiting Nurse Association, Waterbury, Conn.
- Ida Hoffmann, industrial nurse, Greenebaum Tanning Company, Chicago, Ill.
- *Eleanor Scudder, staff nurse, Visiting Nurse Association, Los Angeles, Calif.

ASSISTED PLACEMENTS

- *Hazel Altmann, educational supervisor, City Department of Public Health, Flint, Mich.
- *Martha D. Adam, educational director of the department of educational nursing, Community Service Society, New York, N.Y.
- *Ruth D. Ballam, nursing consultant, American Red Cross, Alexandria, Va.

(Continued on page 593)

*The NOPHN files show that this nurse is a 1943 member.

A Specialized Consultant Helps Improve a General Nursing Service

By JANE TAYLOR, R.N., AND ANNE FALTHER, R.N.

THE DEMANDS of the armed forces for nurses require economy of time and effort in civilian nursing service. Therefore nursing activities must be re-evaluated.

In the past the specialized services have caused considerable duplication in work. To do an adequate piece of work can one be limited to a specialized service? Is such service fair to the patient, the community, or the health department? These are the questions which have been presented to us as specialized venereal disease consultants. If the specialized consultant first has a working knowledge of a generalized public health program, before attempting to advise in a specialized service the whole program becomes a generalized one.

But consultant service is of value only when the local public health nurse feels the need for help and is willing to accept the guidance that can be given by a consultant.

The Selective Service Act of 1940, with the resultant blood testing of every selectee, has provided a mass of statistics on the prevalence of syphilis in a representative sample of the male population. Results of these tests have shown each health department the immensity of the problem and for the first time have given local health administrators the basis for doing an adequate venereal disease case-finding program. As the local nurse

investigates these suspected cases her opportunity for increasing her case load in other services widens, since her "index of suspicion" is raised for such problems as the baby with "snuffles," school child with pink eye, individual with swollen joints, woman giving history of a miscarriage, wage earner with heart disease, individual with personality changes.

Since this is a new approach for many nurses they feel the need for help and are anxious to have assistance in developing their venereal disease programs properly. The venereal disease consultant in answering the recognized need of the local nurse demonstrates that to have a good venereal disease program it must be an integrated part of a good generalized nursing service.

If the venereal disease consultant nurse goes by request into an area and finds the venereal disease problem not serious, but on the other hand discovers that help is needed on a generalized basis, she adjusts her program to meet the situation.

AN EXAMPLE of this was found in a county of 25,000 population where the incidence of syphilis among the selective service group was only 7 per 1,000 men examined. The health department, consisting of a part-time health officer and a nurse with no previous public health training or experience, wanted assistance with its venereal disease

problem. The consultant readily saw that in this locality there was a greater need for developing other services.

She reviewed the positive blood reports and found that the nurse was able to answer only a few general facts about the cases involved. This easily demonstrated the need for better observation and record keeping and gave the consultant an opportunity to review the records of all services.

On observing the nurse during a routine venereal disease call, the consultant found that the major problem in this home was not the 48-year-old grandmother with latent syphilis but the young mother with a new baby. Since the local nurse did not wear a uniform or carry a bag, the consultant used this visit as an opportunity to demonstrate an infant welfare visit. When the consultant revisited the area in six weeks at the request of the local unit, the nurse was in uniform and a bag had been ordered.

In contrast to this procedure the consultant used a different approach in a community of 40,000 which had a syphilis rate of 40 per 1,000 among the selectees examined. Known houses of prostitution had existed here for over 75 years and were accepted by the citizens as a "necessary evil." The local health department had as staff a full-time lay health officer, two nurses (one with preparation in public health nursing), a sanitarian, a laboratory technician and two clerks.

The consultant first visited this unit because so many reported cases gave their original contact as living in this community. After she discussed the problem in a conference with the health officer and mayor, they realized the need for taking some action.

Following several meetings and conferences, the houses of prostitution were closed. Because of the limited number of nurses and the high venereal disease

rate it was necessary for the consultant and nurses to evaluate the entire nursing service. As a result of this study, the city was zoned and two clinics started, a venereal disease clinic with two sessions a week and a child health conference once a week. Staff education was advised and the health officer was urged to develop a program of community health education.

The consultant's service is available as further assistance is needed.

WHEN consultant nurses assist in establishing clues, it gives them an opportunity to discuss and demonstrate clinic management, nursing techniques and the principles of interviewing. Since interviewing is a skill which a new nurse may not possess, the consultant is especially needed to assist with this technique. Many health problems are brought out through interviews with patients and their families which will build up the nurse's generalized case load as well as help her in venereal disease case-finding.

The epidemiological investigations which result from clinic interviews and reports are a most important phase of the venereal disease program. It is here that the venereal disease consultant is of particular value.

Another opportunity for developing the generalized nursing service is through the relationship of the health department to the private physician. The state department of health supplies drugs to any private physician upon request, and in communities where there are no clinics, the department offers a fee treatment plan. The local health officer frequently requests the venereal disease consultant to visit private physicians in company with the nurse. This offers an opportunity to discuss the venereal disease program as well as the other services which the health department offers the physician. Such contacts are very valuable in strengthen-

ing the bond between local physicians and the health department and its nursing service.

In order to give the community maximum service it is essential to establish a working relationship with other agencies. Since syphilis and gonorrhea are frequently long-term illnesses and often involve many social problems, the consultant can demonstrate to the local nurse the value of using existing community agencies. She can illustrate how coordinated action is of much greater value than isolated action.

Dr. Thomas Parran has said, "Citizen interest must be added to cooperation from the medical profession and good public health facilities before a venereal disease program can be called *adequate*." It is often the public health nurse's responsibility to stimulate this public interest in a special public health service.

A truly specialized consultant can help the local nurse only when she understands the total nursing service given and needed in a community. She must be prepared to teach and advise in the generalized service in order to stimulate in the local nurse an interest in the special field. This is particularly true when the venereal diseases are concerned, since communities still exist where it is regarded as a social problem and not as a communicable disease. The venereal dis-

ease consultant is able to assist the nurse in developing a proper community attitude toward venereal disease control.

The venereal disease nursing consultant has a particularly good opportunity now to assist in developing the generalized program since today most nurses in public health agencies feel a definite need for more knowledge relative to venereal disease. In so doing the specialized consultant develops an awareness in the nurse for such needs as:

1. Developing ability in interviewing
2. Utilizing each visit to its fullest extent
3. Establishing and maintaining a good record system
4. Districting and planning work to give the most service with the personnel available
5. Establishing good working relationships with private physicians
6. Building good working relationships with other social agencies
7. Improving clinic nursing procedures

An awareness of the value of these procedures makes the nurse more receptive to suggestions and makes her less hesitant to ask for help.

Thus, while aiding the development of her particular program the specialized consultant assists in improving the entire generalized nursing program.

STANDING ORDERS FOR NURSES IN INDUSTRY

OF GREAT interest to nurses are new standing orders for industrial nurses prepared by the Council on Industrial Health of the American Medical Association. The new orders are comprehensive enough to cover most situations and can be made specific for a particular health service with a minimum of effort on the part of the physician responsible.

Survey shows that only 26 percent are working under written standing orders—a situation not entirely due to indifference, but rather to the

practical difficulty of getting orders written and signed by responsible medical authority.

Their formulation has a deeper significance than a mere statement of procedures. It recognizes industrial nursing as a specialty in the field of public health and is a large stride forward in its integration into the community health program. Copies may be procured without charge by writing to *The Journal of the American Medical Association*, 535 North Dearborn Street, Chicago, Illinois. —H. L. H.

Reviews and Book Notes

THE KENNY CONCEPT OF INFANTILE PARALYSIS AND ITS TREATMENT

By John E. Pohl, M.D. in collaboration with Sister Kenny, foreworded by Frank R. Ober, M.D. 355 pp. The Bruce Publishing Company, Minneapolis and Saint Paul, 1943. \$5.

Dr. Pohl observed the first cases of infantile paralysis in the United States to receive care supervised by Sister Elizabeth Kenny and has worked with her continuously since. In this text he presents and discusses the Kenny concept and treatment of infantile paralysis with which he is thoroughly familiar.

The book is divided into three parts, each devoted to one stage of the disease, acute, convalescent, and chronic. Part one discusses the definition and symptoms of the disease in the acute stage; examination of the patient and detection of spasm by visual observation; analysis of neuromuscular conditions, spasm, alienation, incoordination, and complete nerve denervation; nursing care; treatment of muscle spasm; the respiratory system and muscle stimulation. The convalescent stage is considered in part two, including an introduction to muscle re-education; muscle function; classification, type, action and synchronization of muscles; the principles of treatment in the restoration of function of the neuromuscular system, with many helpful illustrations; balneotherapy and the treated patient. The chronic state and the role of orthopedic surgery and artificial supports is presented in part three.

It is generally agreed that Doctor Ober is correct in his statement found in the foreword: "If the Kenny technique, with its continuous superb nursing, is followed, the physician will find that the affected

parts become soft and relaxed, limitation of motion is not so persistent, and pain subsides remarkably early as compared to other methods. The physical therapist will find that close application of the technique described in the book will gain the maximum amount of recovery more quickly and much more satisfactorily than by the techniques previously employed."

This book should be read and studied by each nurse and physical therapist caring for patients with infantile paralysis.

LOUISE SUCHOMEL, R.N.
Detroit, Michigan

A TEXTBOOK OF MEDICAL DISEASES FOR NURSES

By Arthur A. Stevens, M.D. and Florence Ambler, R.N. 623 pp. W. B. Saunders Company, Philadelphia, fifth edition, 1943. \$2.75.

The Fifth Edition of this textbook shows improvement over the previous editions. The subject matter has been rearranged and set up in units which follow the Curriculum Guide. Certain sections such as the anemias, oxygen therapy, nephritis and the use of sulphonamides have been rewritten and brought up to date. New material has been added, including serum sickness, menopause, obesity and the Kenny treatment for poliomyelitis. However, these subjects have been treated very briefly.

The nursing care of the major diseases follows the discussion of the condition and in a few cases the nursing care has been elaborated. The newer methods of treatment have been included.

The authors have attempted to cover a vast amount of material and in so doing have been brief and in certain instances the material seems incomplete. The

BOOK NOTES

Kenny treatment and diseases of the nervous system are examples.

The book is of convenient size, with easily readable type. The illustrations throughout the book are well chosen.

This text should prove useful to the young student if additional references are used to supplement the portions of the book which are inadequately covered.

THELMA L. STONE, R.N.
New York, N.Y.

HOME CARE OF BONE AND JOINT TUBERCULOSIS

Prepared by Iowa State Services for Crippled Children. T. J. Greteman, M.D., Alice Miller, R.N. 43 pp. 1943.

This handbook will be welcomed by all doctors and nurses working with children who have bone and joint tuberculosis. It is practical and has been clearly and concisely written. Its contents include an over-all view of the disease itself, the general nursing care of these patients and the specific nursing care of patients with tuberculosis of hip, spine and lower and upper extremities. In conclusion, a case summary is given of a patient with tuberculosis of the spine. There are many excellent illustrations in which have been carefully embodied the principles of good posture and body mechanics.

M.S.A.

TEACHING THE INDIVIDUAL

By Ruth L. Munroe. 353 pp. Columbia University Press, New York, 1942. \$3.

This is the third of a series of publications from Sarah Lawrence College giving a "digest and analysis of records kept over a period of many years by teachers" who have pooled their energies in an effort to learn more about the learning processes of individuals. The description of the "rigid type" and the "scattered type" student is made interesting and realistic because Miss Munroe has drawn upon actual case material in sharing the report with her readers.

Since much of the work of the public health nurse is teaching on an individual level this study seems particularly relevant for her use. Certainly the public health nurse, in rendering health service to families, has opportunity to analyze individuals in terms of health "educational syndromes." What public health nurse has not had to admit defeat in working with individuals because she lacked insight into their deep-seated emotional problems?

Intensive case work has proved to be a reliable method of individual analysis. If the findings are baffling perhaps it is because we still lack knowledge or perhaps it is because we have been seeking one method that will be applicable to all individuals. The author points out the danger of doing nothing because we realize our limitations. This is a game at which amateurs may play. Individual analysis does not pre-suppose the skill of a trained psychiatrist. The progress made will be directly dependent upon the capacity for growth of the individual analyst. The procedure has a public health slant in that it deals with normal individuals.

One might wish for more definite conclusions but in keeping with the spirit of the book we must be content to watch developments as they appear. These developments will result from the contribution of many workers over a long period of time.

PEARL PARVIN COULTER, R.N.
Boulder, Colorado

LILLY CRACKELL

By Caroline Slade. 609 pp. The Vanguard Press, New York, 1943. \$3.

Lilly is of mixed blood, "high"—giving her patrician beauty, "low"—giving her a 90 I.Q., and who is to say whence came her dignity, loyalty, love and honesty? She lived her desperate life in a shanty

PUBLIC HEALTH NURSING

on the dumps, believed to be a thorough "Crackell," therefore hopelessly doomed to destitution, delinquency, disease. "You can't change a Crackell," says the Poor Master, writing out a grocery order that will just maintain life.

Mrs. Slade introduces us to Lilly, aged 14. She is 36 in 1942 when, at the end, four sons go to war. The author shows both the ugly horrible details of Lilly's life, and with Freudian meticu-

lousness, Society's methods of attack on pauperism. We are all, professional and lay, on her pages, our motives uncovered, our self-interests bared, our stupid unreason revealed with the clarity of a syllogism.

Read this. You dare not miss it. Novels of Dickens changed English poor laws.

FLORENCE M. FARR
Brookside, N.J.

RECENT PUBLICATIONS AND CURRENT PERIODICALS

GENERAL READING

ANATOMY AND PHYSIOLOGY LABORATORY MANUAL AND STUDY GUIDE. Barry G. King, Ph.D., and Helen M. Rosen, R.N. W. B. Saunders Company, Philadelphia, second edition revised, 1943. 253 pp. \$2.75.

CONVULSIVE SEIZURES. Tracy J. Putnam, M.D. J. B. Lippincott Company, Philadelphia, 1943. 168 pp. \$2.

A lucid and helpful book which will make the reader understand more clearly the method to employ in dealing with convulsive seizures. It is a book written for the patients, their family and friends.

FOOD 'N' FUN FOR THE INVALID. Florence Le Ganke Harris and Dorothy A. Ridler. M. Barrow and Company, New York, 1942. 255 pp. \$2.

A HANDBOOK OF MEDICAL LIBRARY PRACTISE. Compiled by a Committee of the Medical Library Association, Janet Doe, Editor. American Library Association, Chicago, 1943. 640 pp. \$5.

THE LIBRARY KEY: An Aid in Using Books and Libraries. Zaidee Brown. H. W. Wilson Company, New York, fifth edition revised, 1943. 133 pp. 70c.

A guide for students and adult readers in using books and libraries. It includes an explanation of the library and its arrangement, the catalogue, encyclopedia, reference books, note taking and several other helpful hints.

PHARMACOLOGY, MATERIA MEDICA AND THERAPEUTICS. Charles Solomon, M.D. J. B. Lippincott Company, Philadelphia, fifth edition revised, 1943. 823 pp. \$3.

CHILD CARE

CHILDREN AND YOU: A PRIMER OF CHILD CARE. Eva Knox Evans. G. P. Putnam's Sons, New York, 1943. 60 pp. 35c.

SUPERVISED HOMEMAKER SERVICE: A METHOD OF CHILD CARE. Bureau Publication 3296. U. S. Department of Labor, Children's Bureau. Available from the Superintendent of Documents, Washington, D.C. 1943. 36 pp. 10c.

CARE AND FEEDING OF CHILDREN. L. Emmett Holt, M.D. (Revised by L. Emmett Holt, Jr., M.D.) D. Appleton-Century Company, New York, sixteenth edition, 1943. 321 pp. \$2.

YOUR OWN STORY. Marion L. Faegre. Minnesota Department of Health, Minneapolis, 1943. 52 pp. Free. Human reproduction simply explained.

YOUR FIRST BABY. Louise Cripps Glemser. A. S. Barnes and Company, New York, 1943. 90 pp. \$1.

HEALTH EDUCATION

DIRECTORY OF AFFILIATED CARDIAC CLINICS OF THE COMMITTEE ON CARDIAC CLINICS. New York Tuberculosis Association, 386 Fourth Avenue, New York, 1943. 13 pp. Free.

DISTRIBUTION OF HEALTH SERVICES IN THE STRUCTURE OF STATE GOVERNMENT. Bulletin 184. Federal Security Agency, U. S. Public Health Service, Washington, D.C. Available from the Superintendent of Documents, Washington, D.C. June 1943, third edition.

Volume of reprints of articles which have appeared in *Public Health Reports* under the same title.

BOOK NOTES

HEALTH EDUCATION MATERIALS. U. S. Public Health Service, Washington, D.C.

A pamphlet issued by the U. S. Public Health Service listing and explaining their:

motion pictures—length, size, color, sound or silent

transcriptions—length and size

pamphlets—number, price

NURSES FOR DEFENSE. A transcription. Two sides of a record, 20 minutes.

"A discussion by Surgeon General Thomas Parran, Congresswoman Frances P. Bolton, Principal Nursing Consultant Pearl McIver and Ellen Logan, a candidate for nurses' training under the Nurses' Training appropriation bill sponsored by Mrs. Bolton. It tells about the need for more trained nurses during the war period and how with the grants-in-aid the Government is making it possible for many to receive training who would otherwise be unable to afford it."

NUTRITION

HOW BEST TO EAT UNDER WAR CONDITIONS. Fredrick J. Stare, M.D. *The New England*

Journal of Medicine, Massachusetts Medical Society, 8 Fenway, Boston, June 24, 1943. p. 809. 25c per copy.

MANUAL OF INDUSTRIAL NUTRITION. Food Distribution Administration, Washington, D.C. 1943. 23 pp.

The first in a series of pamphlets which are being prepared and distributed by the Nutrition Industry Division, Nutrition and Food Conservation Branch, F.D.A., Washington, D.C.

SOME CENTRAL EUROPEAN FOOD PATTERNS AND THEIR RELATIONSHIP TO WARTIME PROGRAMS OF FOOD AND NUTRITION. Committee on Food Habits, National Research Council, 2101 Constitution Ave., Washington, D.C.

Czech and Slovak Food Patterns. Svatava Firkova-Jakobson and Natalie Joffe.

Hungarian Food Patterns. Natalie Joffe.

Polish Food Patterns. Sula M. Benet and Natalie Joffe.

FEEDING LIBERATED COUNTRIES AND NUTRITION EDUCATION. *Journal of the American Dietetic Association*. April 1943. pp. 259-273.

(N.P.S. Continued from page 586)

NPS is happy to report that Eva L. Nickolson who was a former member of the staff of Nurse Placement Service, functioning in the institutional field, is now its vocational assistant in public health nursing. During her absence of five years, Miss Nickolson took the public health nursing course at the University of Minnesota and followed this with generalized and specialized public health nursing experience in Iowa and Nebraska.

A number of interesting appointments during the last month are not included here because we have not yet received the consent of the nurses for publication. Employers usually are very prompt in giving consent. The nurses sometimes are so busy getting settled in the new work or new location that they somehow overlook

the little blue consent card. Placements are of interest to readers as an indication of the development of and possible trends in public health nursing. Also public health nurses everywhere are interested in new appointments of their friends and former co-workers and often want to congratulate them upon their progress.

NPS wishes to remind former Joint Vocational Service registrants that if they have not already done so, they may still have their JVS records now in storage transferred to NPS. Even if not immediately available for new positions they may still wish to have their professional histories accessible and brought up to date with an eye to the future.

ANNA L. TITTMAN, R.N.
EXECUTIVE DIRECTOR
NURSE PLACEMENT SERVICE

NOTES FROM THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

MAGAZINE STAFF CHANGES

Regretfully it must be reported that on September 1 NOPHN lost Leah M. Blaisdell as editorial consultant. Miss Blaisdell will serve as acting director of Henry Street Visiting Nurse Service. Miss Blaisdell's wide knowledge of public health nursing affairs, her deep and sincere concern for the healthy growth of the profession, her ever-ready interest and resourcefulness in the making of the Magazine must have made themselves felt by all its readers during the past year. All will be glad that Miss Blaisdell has promised to join in Magazine counsels from time to time in coming months so that we may still profit by her enthusiasm and skill.

Ruth Gilbert, chairman of the NOPHN Publications Committee and former assistant editor of PUBLIC HEALTH NURSING, succeeds Miss Blaisdell as editorial consultant. Miss Gilbert is a graduate of Mt. Holyoke College and the Yale School of Nursing. Her public health nursing experience includes two years with the Cattaraugus County Department of Health. Subsequently she received a fellowship from the Commonwealth Fund for a year at the New York School of Social Work, after which she served as mental hygiene supervisor for public health nursing in the Syracuse Department of Health. From 1930 to 1932 Miss Gilbert was assistant director of the NOPHN and assistant editor, devoting considerable time to a study of actual and possible developments of mental hygiene as a part of public health nursing service.

In 1932 she went to Hartford, Connecticut, as mental hygiene supervisor of the Visiting Nurse Association, and in 1939 to New Haven, Connecticut, in charge of social service in the Psychiatric Service in the Community, clinic of the New Haven branch of the Connecticut Society for Mental Hygiene. Miss Gilbert is the author of *The Public Health Nurse and Her Patient*, published by the Commonwealth Fund, New York, in 1940.

IN THE FIELD

Chicago, Illinois, September 9-10—Ruth Houlton attended a meeting of the chairmen of state committees for nurses of Procurement and Assignment Service, called by the Nursing Division of the War Manpower Commission, at Murphy Auditorium, American College of Surgeons. (See p. 541) . . . THE COMMONWEALTH OF MASSACHUSETTS DEPARTMENT OF HEALTH, Boston, September 13—Heide L. Henriksen, new industrial nurse consultant, visited this organization to confer with the supervisory staff about developing advisory service to industrial nurses . . . WORCESTER SOCIETY FOR DISTRICT NURSING, Worcester, Massachusetts, September 15-17—Dorothy E. Wiesner visited the S.D.N., giving them advice about changing report forms and the record system. . . . STATE DEPARTMENT OF HEALTH, Trenton, New Jersey, September 17—Miss Henriksen spent the day conferring with M. Patience Carr, consulting nurse, Industrial Hygiene Service, State Department of Health, on industrial nursing problems. . . . NORTH PROVIDENCE DISTRICT NURSING AND TUBERCULOSIS

NOPHN NOTES

ASSOCIATION, North Providence, Rhode Island, September 27 and 28—Ruth Fisher made a survey of public health nursing services in this community. . . . THE WARREN DISTRICT NURSING ASSOCIATION, Warren, Rhode Island, September 29 and 30—Miss Fisher surveyed the public health nursing services in Warren.

NEW ORTHOPEDIC MATERIALS

New publications on poliomyelitis now available should be especially helpful at this time. A pamphlet, "Nursing Care of Patients with Infantile Paralysis—Including Nursing Aspects of the Kenny Method," with a "Guide for Nurses" and a "Guide for Parents" has been prepared by the Joint Orthopedic Nursing Advisory Service jointly with a committee of agencies working with the Division of Physically Handicapped Children of the New York City Department of Health. Diagrams for placing and cutting packs are included. Free copies may be obtained from the National Foundation for Infantile Paralysis, 120 Broadway, New York 5, New York.

A new JONAS folder contains reprints on the cause, treatment and nursing care of the disease. This may be borrowed for two weeks, at no charge except for transportation costs.

Two sets of slides are now available from JONAS—one, a set of 72 black and white 16 mm. slides on Orthopedic Operations; another, a set of 30 Kodachrome 16 mm. slides on Care of the Patient in the Respirator. The first group depicts the common orthopedic operations (not including nursing care demonstrations) and is intended for the orthopedic nurse teacher who is undertaking instruction hitherto done by doctors. A script accompanies the slides. The latter group deals primarily with the placing of the patient in the machine.

HONOR ROLL

The next and final edition of the 1943 Honor Roll will be published in the December magazine. If every member of your full-time nursing staff is a member of the NOPHN, your agency is eligible for an Honor Roll Certificate. One-nurse agencies are eligible, too.

Names of agencies received after November 10th cannot be included in the magazine.

Let us know at once if your agency is eligible.

ARIZONA

Patagonia—Santa Cruz County Health Unit

ARKANSAS

*Hot Springs—Metropolitan Life Insurance Nursing Service

CALIFORNIA

*Coalinga—Elementary and Secondary Schools

*Los Angeles—Curriculum in Public Health Nursing, University of California

*San Diego—Visiting Nurses

San Rafael—Marin County Chapter, American Red Cross

CONNECTICUT

*East Hampton—Public Health Nursing Association

*Guilford—Public Health Nurse Association

*Plainville—Public Health Nursing Association

*Washington Depot—Visiting Nurse Association

Windsor—Public Health Nurse Association

FLORIDA

*Pensacola—Estambia County Health Department

GEORGIA

Preston—County Nurse

IDAHO

*Boise—Metropolitan Life Insurance Nursing Service

ILLINOIS

Canton—Fulton-McDonough Bi-County Health Unit

*Champaign—Champaign-Urbana Public Health District

*Freeport—Stephenson County School Nursing Service

*Agencies which have been on the Honor Roll for five years or more.

PUBLIC HEALTH NURSING

- Glen Ellyn—DuPage County Tuberculosis Sanatorium Board
- *Macomb—Western Illinois State Teachers College
- Oak Park—John Hancock Life Insurance Company
- Peoria—County Health Department
- *Springfield—Sangamon County Public Health Nursing and Tuberculosis Association

INDIANA

- *Terre Haute—Public Health Nursing Association

IOWA

- *Algona—Iowa Public Health Nurses, District No. 10
- Guthrie Center—County Nursing Service
- Iowa City—Johnson County Nursing Service
- Manchester—County Nurse
- *Winterset—Public Schools

KANSAS

- Topeka—City-Shawnee County Health Department

KENTUCKY

- Albany—Clinton County Health Department
- Pineville—Bell County Health Department

LOUISIANA

- Alexandria—Central Regional Office
- Bastrop—Morehouse Parish Health Unit
- Colfax—Grant Parish Health Unit
- DeRidder—Beauregard Parish Health Unit
- Farmerville—Union Parish Health Unit
- Harrisonburg—Catahoula Parish Health Unit
- Lafayette—Southern Regional Office
- Leesville—Vernon Parish Health Unit
- Lutcher—St. James Parish Health Unit
- Minden—Webster Parish Health Unit
- Monroe—Northern Regional Office
- New Orleans—Division of Public Health Nursing, State Health Department
- Oak Grove—West Carroll Parish Health Unit
- Oberlin—Allen Parish Health Unit
- St. Joseph—Tensas Parish Health Unit

MAINE

- Dover-Foxcroft—Piscataquis County Nursing Service
- *Lewiston—Lewiston-Auburn Tuberculosis Association

MARYLAND

- *Bethesda—United States Public Health Service

MASSACHUSETTS

- *Greenfield—Franklin County Public Health Association, Inc.
- *Richmond—Community Health Association of Richmond and West Stockbridge

- *Sturbridge—Community Nursing Service
- *West Springfield—Board of Health
- *Worcester—Society for District Nursing

MICHIGAN

- *Detroit—City Department of Health

MINNESOTA

- *Duluth—St. Louis County Health Department
- *Mankato—Minnesota Department of Health, District No. 2
- Nopeming—Nopeming Sanatorium

MISSOURI

- *Clayton—St. Louis County Health Department
- *Independence—Jackson County Health Department
- *Jefferson City—State Board of Health, Division of Public Health Nursing
- Kirkville—State Board of Health, District No. 10
- Mt. Vernon—Lawrence County Public Health Nursing Service
- *Owensville—State Board of Health, District No. 6
- *St. Joseph—Organization for Public Health Nursing

MONTANA

- Butte—Silver Bow County Nurses
- Havre—Hill County Public Health Nursing Service

NEW HAMPSHIRE

- *Laconia—Nursing Service

NEW JERSEY

- *Red Bank—Monmouth County Organization for Social Service, Inc.
- *Woodbury—Visiting Nurse Association

NEW MEXICO

- *Mosquero—Harding County Health Department

NEW YORK

- Batavia—Infant Welfare Association
- Geneseo—Livingston County Public Health Nursing Service
- *Geneva—American Red Cross, Visiting Nurse Service
- *Ilion—Metropolitan Life Insurance Nursing Service
- Jamestown—District of N. Y. State Department of Health
- Malone—Franklin County Public Health Nursing Service
- *Mt. Vernon—Visiting Nurse Association
- *Olean—Cattaraugus County Health Department
- Troy—Rensselaer County Public Health Nursing Organization

NOPHN NOTES

NORTH CAROLINA

- Asheboro—Randolph County Health Department
- Hickory—Metropolitan Life Insurance Nursing Service
- Mt. Airy—Surry County Health Department

NORTH DAKOTA

- *Lisbon—Ransom County Public Health Nursing Service

OHIO

- *East Liverpool—Department of Health
- *Middletown—Metropolitan Life Insurance Nursing Service

OKLAHOMA

- Watona—Blaine County Health Department

OREGON

- *Lakeview—Lake County Public Health Service
- Portland—Department of Nursing Education, University of Oregon Medical School
- Portland—Visiting Nurse Association
- *Salem—Metropolitan Life Insurance Nursing Service

PENNSYLVANIA

- *Lebanon—Visiting Nurse Association
- *Montrose—American Red Cross

RHODE ISLAND

- *Providence—Daval Rubber Company
- *Providence—City Health Department
- Providence—State Department of Public Health

SOUTH DAKOTA

- Onida—Sully County Nursing Service
- *Sioux Falls—City Health Department

TEXAS

- *Austin—Texas Tuberculosis Association
- *Bryan—Texas State Health Department, District No. 4
- Dallas—Methodist Hospital Clinic—Out Patient Department
- *Houston—Southern Pacific Lines
- Sierra Blanca—Hudspeth County Nursing Service

UTAH

- *Salt Lake City—Metropolitan Life Insurance Nursing Service

VERMONT

- Montpelier—Public Schools

WASHINGTON

- Ritzville—Adams County Health Department

WEST VIRGINIA

- Clarksburg—Harrison County Tuberculosis Association

WISCONSIN

- *Appleton—Board of Education, City School
- Crandon—Forest County Public Health Service
- Fox Point—Health Department
- Green Bay—Brown County Public Health Service
- Green Bay—Visiting Nurse Association
- *Marinette—Metropolitan Life Insurance Nursing Service
- *Milwaukee—Wisconsin Anti-Tuberculosis Association

ALASKA

- Eklutna—Vocational School
- Juneau—Public Health Service
- *Juneau—Alaska Territorial Department of Health
- Ketchikan—Public Health Nursing Service
- Palmer—Matanuska Valley Community Health Service
- Seldovia—Public Health Nursing Service
- Seward—Public Health Nursing Service

TERRITORY OF HAWAII

- Honolulu—Bureau of Public Health Nursing of Oahu Island

WHAT TO READ, BOARD AND COMMITTEE MEMBERS!

You can bring yourself up to date on the national nursing picture by reading the editorial, "Procurement and Assignment," the "Criteria of Essentiality," Lieutenant Colonel Blanchfield's article and the statement by the Directing Board of Procurement and Assignment Service of the War Manpower Commission. On page 599 read how every nurse in your community is to be classified by the local committee for nurses. Here are described the five categories of availability for military service or essentiality for civilian service, with some details as to their application. Read also Miss Goggans' "Oh Nurse, the Baby is Coming and the Doctor Isn't Here." Don't be caught without proper procedure in mind like a taxi driver who recently drove a friend momentarily expecting a baby up to the Medical Center. He looked at her in anguish as she climbed into the taxi dragging a pillowcase into which a few items had hastily been packed, and cried, "Oh no, not in my taxi, lady!"

NEWS

Highlights on Wartime Nursing

ORGANIZATION FOR PROCUREMENT AND ASSIGNMENT

A meeting of chairmen of state committees for nurses of Procurement and Assignment Service, War Manpower Commission, was held at the Murphy Memorial Auditorium of the American College of Surgeons, Chicago, September 9 and 10. Represented were 44 states and the District of Columbia. Executive secretaries of state nursing councils and representatives of various national organizations were also invited. Ruth Houlton attended for NOPHN.

Speakers on the first day presented various aspects of the plan for procurement and assignment of nurses. The second morning was devoted to an "Information Please" session when questions for the audience were answered by a panel of discussants. In the afternoon small groups were formed, by states according to size of nurse population, for more detailed discussion.

ORGANIZATION

The organization, functions, and some of the procedures worked out by the Nursing Division in Procurement and Assignment Service and approved by the Directing Board were described as follows:

National. The Directing Board of Procurement and Assignment Service, of which two nurse members (Katharine Tucker and Laura Grant) of the Nursing Advisory Committee are members, is the policy making body in the Procurement and Assignment Service. The recommendations of the Directing Board are put into action by the Executive Officer (Dr. M. E. Lapham), assisted by his staff, who is directly responsible to the director, Bureau of Placement, War Manpower Commission. The nursing staff consists of an assistant executive

officer (L. Louise Baker), an assistant (Ruth A. Heintzelman), and four field consultants.

The advisory committee to the Directing Board makes recommendations regarding their various fields. The Nursing Advisory Committee,* representing the various aspects of nursing service, makes recommendations to the Directing Board, regarding plans and policies for the Nursing Division. In addition, nursing is represented on the following advisory committees: hospitals, public health, industrial health, allocations, and information. There is in addition an advisory committee on nursing education, made up entirely of nurses. These committees are concerned primarily with establishing criteria for determination of essentiality (p. 543) for the different groups represented by the Procurement and Assignment Service and dissemination of information regarding the pro-

*Katharine Tucker, director of the Department of Nursing Education, University of Pennsylvania, chairman; other members of the committee—Shirley Titus, executive secretary of the California State Nursing Council for War Service; Irene Murchison, supervisor of nursing education, Colorado State Board of Nurse Examiners; Lola Knoller, chairman of Private Duty Section, Wisconsin State Nurses Association; Dr. Claude W. Munger, director of St. Luke's Hospital, New York City; Mrs. Edward Walsh, chairman, Voluntary Special Services, Red Cross Chapter, St. Louis, Missouri; Laura Grant, superintendent of nurses, New Haven (Conn.) Hospital; Alma C. Haupt, director of Nursing Bureau, Metropolitan Life Insurance Company, New York City. Liaison members include the NNCWS, ARC, and government agencies having a substantial interest in nursing. These are the Army, Navy, Veteran's Administration, USPHS (Hospital Division and States Relations Division), Children's Bureau, Office of Indian Affairs, OCD, Civil Service Commission.

NEWS NOTES

grams. The National Nursing Council for War Service acts as a consultant office to the Procurement and Assignment Service.

The headquarters office of Procurement and Assignment Service in Washington, which is known as the Central Office, outlines general policies and supplies the procedures and methods by which the program of procurement and assignment of nurses will be instituted and maintained.

State. The supply and distribution committee of the state nursing council for war service will act as the state committee for nurses of Procurement and Assignment Service. The chairman of this committee will receive an appointment from Paul V. McNutt, chairman of the War Manpower Commission, and will serve without compensation, as do all other state chairmen of Procurement and Assignment Service. She will serve on the state advisory committee, which is composed of the chairmen of the other state committees of Procurement and Assignment Service, and representatives from the state nurses association, medical societies, dental societies, labor organizations, the American Red Cross, Office of Civilian Defense, or such other groups as may be appointed.

In the states with the greatest problems in the procurement and assignment of nurses, additional personnel will be provided by the Central Office. The headquarters of the state committee will be known as the State Office for Nurses of Procurement and Assignment Service.

The state offices are responsible for carrying out the program of procurement and assignment of nurses.

Local. The local nursing councils for war service, or a supply and distribution committee of the local councils, will act as the local committees for nurses of Procurement and Assignment Service. They are responsible for carrying out the functions of the Nursing Division in the community which they serve. They will work closely with the local committees for physicians.

CLASSIFICATION OF NURSES

Procedures have been worked out for classification of nurses by the local committees, as to their availability for military service or essentiality for civilian service. This applies not only

to nurses eligible for military service but to all nurses. Local decisions as to classification of nurses eligible for military service will be forwarded on individual clearance forms to the state committee for review and final action. If approved the state committee will send the clearance form to the local Red Cross recruitment committee where the nurse resides. If the individual nurse or the institution employing her does not agree with the classification made by the local and state committees, either may request the state committee to reconsider. If the original decision is upheld, final appeal may be sent to the Directing Board, Procurement and Assignment Service.

The local committee for nurses will classify each nurse residing in its jurisdiction in one of five categories:

Class I. Available for military service, not holding an essential position, and potentially qualified for military service

A. Unmarried

B. Married

1. Married with no children and not maintaining a home with husband
2. Married with no children and maintaining a home with husband
3. Married with children, none of whom are under 14 years of age

Class II. Available for relocation

A. Outside the community

B. Within the community

Class III. Essential for limited duration or until a replacement can be secured

A. For hospital service

B. For public health

C. For industry

D. For nursing education

E. Other

Class IV. Essential for unlimited duration

A. For hospital service

B. For public health

C. For industry

D. For nursing education

E. Other

Class V. Not available for either military or emergency civilian service because of physical disability, age, or other reasons.

Explanation of the Above Classification

Class I. A nurse under 45 years of age, with

no children under 14 years of age, not essential in her present position, who is presumably physically qualified for service with the armed forces.

A nurse in Class I-B-2 or I-B-3 should not be declared available to the Red Cross Nurse Recruitment Committee by the State Committee until all nurses in Classes I-A and I-B-1 have been exhausted, unless she has indicated a desire to serve with the armed forces. She should be encouraged to accept an essential civilian nursing position, at which time she will be reclassified as essential.

Class II. A. A nurse not eligible for military service and not essential in her present position, but able to carry on civilian nursing work, who might be willing to consider relocation in another section of the state or country where the need for her services is greater. Relocation might be on a temporary or a permanent basis.

B. A nurse not eligible for military service nor essential in her present position, physically able to accept another type of essential nursing work. Example: A nurse, not eligible for military service, who is not needed for private duty would be classified as II-B.

Class III. A nurse who may or may not be eligible for military service for whom it is assumed that a satisfactory substitute can be obtained. Example: A head nurse in a hospital without a school of nursing who could be replaced by a qualified nurse who is not eligible for military service would be classified as III-A.

Class IV. An essential nurse who may or may not be eligible for military service for whom, under present conditions, the chances are small for finding a satisfactory replacement. Example: A director of a visiting nurse association would be classified as IV-B.

Class V. A nurse who cannot be expected to engage in active nursing because of age, physical disability, or other reasons.

OTHER TOPICS DISCUSSED.

Among other matters discussed at the Chicago meeting was the need for up-to-the-minute information about numbers and location of nurses. A registration of nurses will probably be taken within a few months, preceded by an

intensive publicity campaign. The recent slump in nurse applications for military service was deplored. This is very serious in view of the second front military action now developing.

Colonel Florence A. Blanchfield of the Army Nurse Corps (p. 546) and Lieutenant Mary Benner of the Navy Nurse Corps gave interesting information including figures not previously released. They presented convincing proof that the nurses requested for military service must be found. Nor can they all be young graduates as a certain percentage must be qualified to organize and administer services, to teach, and to supervise.

NURSING COUNCIL

Questions pouring in from thousands of young women all over the country about the U. S. Cadet Nurse Corps have pointed up the need for information centers. By agreement among the American Hospital Association, the Catholic Hospital Association, the Protestant Hospital Association, and the USPHS and the NNCWS, *the local hospital is being asked to become this information center*, whether or not it has a school of nursing. Hospitals offer a number of advantages. They are well distributed, their location generally known, are always open. They have a vital interest in maintaining the potential supply of nursing service which the U. S. Cadet Corps is designed to build up.

State and local nursing councils for war service are still responsible for total recruitment programs in their areas, and will be expected to assist with all plans for giving out information about the Corps. The local nursing council should take the initiative in getting in touch with the hospitals in its area to make mutually satisfactory arrangements for answering inquiries directed to hospitals. Speed is essential in getting these information centers under way. Volunteer aid must be enlisted if needed for manning the information desks. Where no council exists, the director of nursing service or the hospital administrator will take responsibility for giving out information. However, the secretary of the state council will know the areas where no local councils exist and immediately should get in touch with all hospitals in these areas to make sure that they have the

necessary local information and the leaflets and posters prepared for the purpose.

An institute is scheduled for October 1 and 2 for nurses who will conduct recruitment meetings at colleges and other schools. Among those lent by their institutions for part-time recruitment are: Jessie Black, Johns Hopkins School of Nursing; Sarah Colville, Mrs. Anna Cole, and Lucy Dade, Vanderbilt University School of Nursing; Cornelia Erf, Western Reserve University School of Nursing; Elizabeth Howland, Mary Stewart, and Eugenie De Armit, Boston Visiting Nurse Association; Martha Johnson, Johns Hopkins; Elizabeth Jung, University of Cincinnati School of Nursing; Mrs. Arthur Lowery, Georgetown Hospital; Mildred Newton, University of California School of Nursing; Mrs. Estelle Massey Riddle (of the staff of the National Nursing Council for War Service); Mrs. Frank Stevenson, Cincinnati Deaconess Hospital; Elisabeth Phillips, Dorothy Rusby, and Lucy Gordon White of Henry Street VNS; Mrs. Whiting Williams of Cleveland.

Fall institutes of the Committee on Educational Field Service were started September 8

and will continue until November 29, in states which accepted the offer of the committee to conduct meetings (generally for two days) of nursing education administrators who seek counsel concerning their accelerated programs. Each discussion centers around one of the three following topics: better organization and use of existing educational and community resources; better preparation and guidance of faculty members; better student guidance and personnel policies.

New members of the Council staff are: Eleanor Lee, formerly of the Columbia Presbyterian School of Nursing, who will act as part-time secretary for the College Field Unit; Mary Louise Foster, formerly personnel director of Henry Street, who will head the Clearing Bureau; Gertrude Binder, formerly director of the Social Service Exchange and editor of the *Federation of Social Agencies* magazine in Pittsburgh, who will join the public information staff; Mrs. John W. Lynch, formerly publicity director and instructor in journalism at Mt. Holyoke, who will work principally with the College Field Unit.

From Far and Near

- The following annual meetings are being held this month and next:

Connecticut—Connecticut State Nurses Association, Hotel Stratfield, Bridgeport. October 20-21.

Massachusetts—Massachusetts Organization for Public Health Nursing, New England Mutual Hall, Boston. November 4. Massachusetts League of Nursing Education, Massachusetts State Nurses Association, Hotel Statler, Boston. November 4-5.

Oklahoma—Oklahoma State Organization for Public Health Nursing, Oklahoma State League of Nursing Education, Oklahoma State Nurses Association, Muskogee. October 29.

Pennsylvania—Pennsylvania State Organization for Public Health Nursing, Pennsylvania State Nurses Association, Pennsylvania League of Nursing Education, Penn Harris Hotel, Harrisburg. October 27-28.

- The National Association for Nursery Education will hold its 10th Biennial Meeting in Boston, October 22-25 at the Hotel Statler. This will be a work study conference on "The Community Serves the Child in War and Peace."

- The following new appointments have been made to the staff of the Children's Bureau:

Alice F. Brackett, as assistant director of the nursing unit, Division of Health Services. Formerly regional consultant nurse for the Children's Bureau in San Francisco.

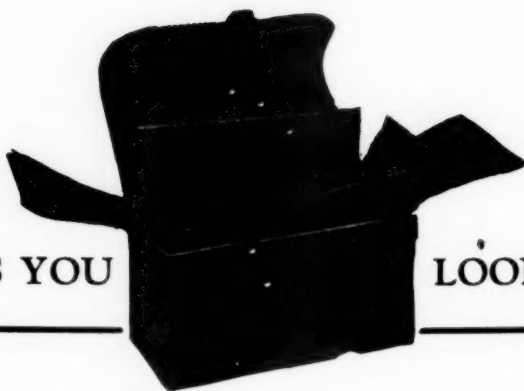
Joy B. Stuart, as regional consultant nurse in the San Francisco office. Formerly consultant nurse in maternal and child health, Utah State Department of Health.

Lucile Perozzi, as regional consultant nurse, Midwest Area. Formerly director, Division of Public Health Nursing, Oregon State Board of Health.

(Continued on page A12)

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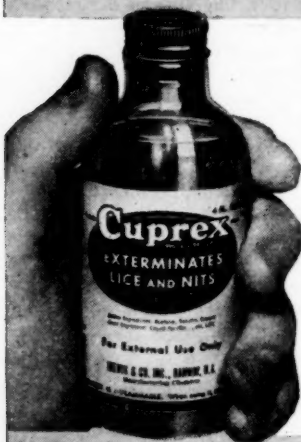
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PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

Bottlenecks in Nursing Services

THIS is the moment of crisis and opportunity for public health agencies as well as hospitals. Inadequate nursing service presents the crisis. The opportunity lies in breaking certain bottlenecks that contribute to the inadequacy. It is the privilege of public health agencies to help improve the situation.

One of the bottlenecks—an insufficient number of student nurses—is rapidly being eliminated. Recent reports from the Division of Nurse Education, U. S. Public Health Service, indicate unprecedented interest in professional nursing as a career.

The current critical bottlenecks are insufficient educational personnel, lack of necessary clinical facilities and inadequate housing. Of the three, greatest progress has been made in solving the housing problem. Recent arrangements between the Public Health Service and the Federal Works Agency should make it possible for housing facilities to keep pace with recruitment.

Comparable progress must be achieved in breaking the bottlenecks of insufficient educational personnel and necessary clinical facilities. Educational facilities can be expanded in some schools by total use of existing facilities. All present affiliations must be retained and new ones established. By doing this, a triple purpose will be accomplished: enrollment will be increased, the total nursing care for patients in the home hospital will be increased; and additional care will be

available for patients in the affiliating institution or agency.

If every school established a psychiatric affiliation and admitted as many student nurses as could be accommodated in its student residences, admissions this year could be increased by 10 percent. The import of such affiliations is obvious in terms of nursing care for psychiatric institutions both now and for years to come. Obvious also is the fact that future nurses in public health agencies as well as hospitals would be better equipped to handle this vital phase of postwar rehabilitation.

Also in connection with the bottlenecks of housing and clinical facilities it is important that on reaching the senior period, cadets be given outside assignments. This turnover will create immediate facilities for additional new students. Retention of the senior cadet in the school has been likened by Lucile Petry, director of the Division of Nurse Education, to clogging an assembly line with completed planes.

It is anticipated that a limited number of selected senior cadets may be assigned for experience to public health agencies. Such agencies stand ready to derive two important benefits from senior cadets in addition to helping eliminate one of the serious educational bottlenecks. First, they receive services practically equal to those of a graduate nurse; second, they help increase the future supply of public health nurses since these students may

PUBLIC HEALTH NURSING

decide to enter the field after graduation.

Certain recommendations regarding public health experience for senior cadets are being developed by the Joint Committee on Integration of the Social and Health Aspects in Basic Curriculum recently appointed by NOPHN and NLNE (see page 649). These recommendations will determine the type of agencies to use senior cadets. They will also set forth the respective responsibilities of the agencies and the senior cadets assigned to them.

A wise provision and safeguard for the type of supervised experience to be given senior cadets is that it must be accept-

able to both the home school and the state board of nurse examiners. Agencies wishing to have senior cadets assigned to them have been advised to deal directly with the nursing schools in their areas.

These bottlenecks must be broken through. Recruitment cannot be allowed to forge ahead of the facilities available for new recruits. Each school must determine at once the factors limiting its expansion, and try to eliminate them. Every agency of the medical and nursing professions—particularly every public health agency—can aid and hasten this process.

The Professional-Lay Team

IT IS MOST heartening to the NOPHN to have such a distinguished person as Dr. Dean A. Clark write an article on the subject, "Broadening the Base of Community Participation in Public Health," for since its very inception the NOPHN has emphasized the importance of lay participation in the public health nursing program. In fact, the choice of its name was meant to convey that public health nursing is public health nurses plus board and committee members, volunteers and all interested citizens.

A layman is credited with the original conception of public health nursing. We are all familiar with the story of how farsighted William Rathbone of Liverpool, England, persuaded a nurse to go into the homes of the neglected sick and give them care; how he stood back of her and encouraged her when it seemed as though she could no longer endure the misery with which she came in contact. We also know about the pioneer citizens of this country who against almost in-

surmountable difficulties established organizations to send qualified nurses into people's homes to teach the ways of health. Perhaps some of these early laymen were too possessive about the organizations they founded and recognized no clear distinction between "almsgiving" and nursing. That may be; it is not important now. What is important is that they had the vision to see the imperative need of instructive visiting nursing, that they founded a great movement and blazed a trail for us to follow.

In the early days of "district nursing," lay participation, except at campaign money-raising time, was limited to a selected handful of board members. Along with money-raising they had to begin the difficult task of bringing about thorough-going public acceptance of their agency's work. Ways of closer cooperation with other community organizations had to be developed. At the present time, with Community Chests and the War Fund in many places releasing board

INFANTILE PARALYSIS EPIDEMIC

members from these specific tasks, they have found more time for study. They are devoting this added time to the broader and national aspects of public health nursing so they can the better fulfill their responsibilities as policy makers and interpreters for their own associations and for public health nursing. As Dr. Clark points out, delivering health services of all kinds is a professional job "while the distribution of these services is a public problem dependent not only on professional techniques but upon general social, economic and psychological factors over which the health professions have little or no control." Therefore we can see how naturally and steadily boards of directors have become more representative of their communities.

Gradually volunteers joined board and committee members as active lay participants. Official health departments, convinced that their public health nursing programs could best be safeguarded by advice from the laity, formed citizen committees and in some cities also organized extensive volunteer programs. With the critical shortage of nurse power, volunteer assistance in both public and private agencies has become important.

In recognition of the volunteer's indispensable role in public health nursing, **PUBLIC HEALTH NURSING** magazine this month introduces the first of six "Volunteers of the Month." Our first volunteer from Seattle, Washington, demonstrates the truth that board members are also volunteers and volunteers often are active or future board members. These articles, although they give individual recognition to only six women, are intended as a tribute to the thousands of other volunteers who are contributing outstanding service in all sections of the country.

Yes, we can say that the base of community participation in public health is ever widening. Let us endeavor to make this true in every state and territory that is privileged to have a public health nursing service. Let us who are board and committee members and volunteers continuously keep informed on the latest trends in public health nursing. Let us not forget that we must back our NOPHN not only by our understanding and activities but also by becoming members.

—LYDIA B. STOKES, CHAIRMAN
BOARD AND COMMITTEE MEMBERS SECTION
NATIONAL ORGANIZATION FOR
PUBLIC HEALTH NURSING

Preparing for an Epidemic of Infantile Paralysis

WHAT IS THE responsibility of the public health nurse and the public health nursing agency in an epidemic of infantile paralysis?

The general principles of public health nursing and health teaching which apply to the prevention and control of any communicable disease are important in an epidemic of poliomyelitis. The public health nurse can help to allay the panic which so often accompanies an epidemic

by giving information to the parents concerning measures which the health department has advised for control of the epidemic and community resources for care and treatment.

Since few communities can provide sufficient institutional facilities to meet the demands of a large scale epidemic some patients must be cared for in their homes. Public health nurses should be

(Continued on page 636)

Broadening the Base of Community Participation in Public Health

By DEAN A. CLARK, M.D.

IT IS a privilege which I greatly appreciate to be able to take part in today's discussion in such distinguished company, before your annual meeting. The general subject, "Building Community Support for Public Health," is among the most important and challenging now before persons working in the fields of health and medicine, and I am particularly glad to talk about "Broadening the Base of Community Participation in Public Health."

We have heard from Dr. Stebbins and Mr. Folks how community support is being built up in New York City and New York State. These are examples of which you should be justly proud, and, even more important it seems to me, they are examples from which the nation as a whole can greatly profit. For if community support for public health is a vital necessity in *this* city and state, it is equally so in every city and state and in the health activities of the federal government.

Up to the present, however, there are few examples of public participation in health planning on a national scale. This is natural enough and should not be carelessly condemned, for it is undoubtedly sound that these patterns should first be developed locally and that national patterns should be based upon the best in local and state experience. Moreover, the federal role in health and medical activities has been extensive only in recent years so that full public participation has

hardly been possible as yet. It is not easy, therefore, to point out specific examples of community participation on a national basis (for the nation is a "community" no less than is a village), but some of the reasons why community participation is desirable on a national as well as a local scale are fully apparent and ought to be widely discussed. Indeed, there are at least three reasons why public participation in health planning and activity is generally more important now than ever before, whether at local, state, or national level. First is the fact, clear to all of us, that official agencies of public health are steadily increasing in number, size, and in effectiveness. Correspondingly, their programs are steadily broadening to include more and more of the functions which properly belong in the field of preventive medicine. No one, I believe, questions the desirability of having these functions assumed by qualified, permanent, tax-supported official agencies. It is indeed the glory of voluntary agencies in the health field that they stimulate and initiate new plans and new activities with the express hope that official agencies will adopt them as soon as they are staffed and trained to do so.

But as official agencies grow larger and stronger, it is more essential than ever that public participation also grow larger and stronger. Advisory committees of the public, such as those for which Neighborhood Health Development, for example, is so largely responsible in New

BROADENING COMMUNITY PARTICIPATION

York City, offer the public health official an intimate knowledge of the needs, desires, and goals of his community and an opportunity to educate the community in the purposes and methods of his program that no other channel affords. Such committees also serve to encourage flexibility and change—healthy growth, in short—in the official agency itself, and thus to minimize the dangers of the subtle development of a smug and bureaucratic officialdom, which we would all deplore. We must certainly avoid the attitude of one upstate New York city health officer who said to me once, in all seriousness, "Give me two more public health nurses and the health program in this city will be perfect." Such a statement would surely have been impossible had there been real community participation in public health work in that city. Thus, we may say that the trend toward increasing the scope and influence of official public health agencies, of whatever governmental jurisdiction, is commendable and progressive exactly in so far as it is accompanied by a corresponding increase in active community interest and participation in official health activities.

A SECOND reason why it is peculiarly desirable to broaden the base of community participation just now is the growing public demand that government take a hand in providing not only preventive services but diagnostic and curative services as well. Indeed, there is an increased awareness in the public mind, that the distinction between preventive, diagnostic, and curative services is largely an artificial one—that they are all health services and that the effectiveness of any of them is intimately bound up with the effectiveness of them all. I do not wish here to go into the question of how extensive government activity should be in the diagnostic and curative fields—I need

hardly remind you that it is already very extensive in regard to special types of illness, notably tuberculosis and other communicable diseases and mental illness; and in regard to special groups of persons, like soldiers, sailors, veterans, merchant seamen, Indians, low-income farmers, and needy and medically needy persons generally. Nor is this the occasion for discussing in detail the question of how tax-supported diagnostic and curative services can best be organized to deliver care of high professional quality in the most economical manner. It can be said with certainty, however, that these and allied problems are the subject of discussion today among persons in all walks of life and that even while we are still at war, more government activity in these fields may be necessary if we are to cope successfully with the national difficulties of supplying even minimum health services while our professional personnel are much reduced in numbers.

Public representation in the planning and distribution of diagnostic and curative services which are so peculiarly services to individuals rather than to the mass is urgently needed, if the entrance of government into these new fields is to achieve satisfactory results. For, although the technical problem of delivering health services of all kinds is professional in character and should be guided by persons of professional training, the distribution of these services is a public problem, dependent not only upon professional techniques, but upon general social, economic, and psychological factors over which the health professions have little or no control. Ultimately, only the public can determine how and to what extent these general factors should be modified—so that it will be the public which will decide, in the long run, how and how far government should go in

PUBLIC HEALTH NURSING

aiding to distribute diagnostic and curative health services.

What all of this means, of course, is that now, more than ever, we should make every effort to initiate and foster the fullest community participation in public health services, so that we can learn what the community needs and wants with regard to medical care, and so that the community can learn something about the technical and professional problems involved. Only through such joint action can we hope for real progress in this most widely discussed and rapidly expanding field.

THIRD, and lastly, there is particular need for broadened community participation at this time because of the growing realization on the part of all of us that health services alone are not enough; that the best and most complete system of preventive and curative medical care can be only a part in the whole social and economic structure of the community—or of the Nation. Without adequate public voice in our councils, we in the health field—like those in any other field—are too apt to lose sight of the close interdependence of all the community's social circumstances. Good health is hardly to be expected if housing is bad, nutrition inadequate, and poverty stifling.

That is not to say that advances in public health services, whether preventive or curative, should await perfection in the whole broad realm of social security. But we must go forward together if our end results are to be the best—and indeed we must at least know what the problems are in these other fields if even our immediate daily work in public health is to be reasonably effective. Clearly, this can be achieved, locally or nationally, only through active, organized public participation in our programs—and we

may add the converse—through participation by those in health and medical professions in other fields of social action.

It is urgent, then, to broaden the base of community participation in public health for these three reasons: first, because of the trend toward increasing the scope of activity of official health agencies; second, because of the growing movement toward government activity in diagnostic and curative health services; and third, because of the deepening understanding that health services cannot function alone, but must be closely tied up with the other social programs of the community—and the Nation.

If the urgency of this task be granted, there still remains the question of how to obtain the broadened public participation we ought to have. Here again, one cannot easily give blueprints for any governmental level, but we can see some basic principles from what has already been learned through action. The first and most fundamental principle is that representation should be sought from a real cross-section of the community. Perhaps Mr. Gallup could tell us the statistical mechanisms for doing this, but in social organization we cannot rely upon a statistically random sample. It is axiomatic that we can reach people best through their own groupings: lodges, clubs, churches, parent-teacher associations, unions, and hosts of others. Where organizations are not developed, we may have to go direct to individuals.

BUT THE important point is not *how* to reach people but *what* people to try to reach. It is all very well to rely upon the educated and trained residents of a community for an initial boost, but continuing to rely on these people smacks of the "Lady Bountiful" attitude—it engenders the old notion—still popular in some parts of the globe—that the "top"

BROADENING COMMUNITY PARTICIPATION

people of a community know what is best for all the other people. No. True *community participation means real community representation*—you can't know what the butcher and baker and spot-welder need and want unless you have butchers and bakers and spotwelders on your committee.

A second principle in developing a broader popular base is equally obvious. There should deliberately be a large turnover of volunteer committee workers. This is what I mean: Committee appointments should be short-term and should be rotated so that as many people join in as possible, each doing some small, circumscribed job. People get satisfaction out of doing something concrete, where they can see results. Of course, it is necessary to have steady long-term workers, too, but real broadening of community participation cannot be achieved with these old stand-bys alone, no matter how representative they may be of a wide cross-section of the people.

Finally, true community expression can be secured only if the participants live in and belong to the organic life of the community. The best-trained physician, social worker, or nurse who comes in from outside a town is a poorer representative for that town's needs and aspirations than is the town barber, who lives there and knows the day by day living problems.

All too often the public health nurse is a town's only representative in planning health programs for the county or the state. Yet the nurse may not even live in the community she represents, or she may have been assigned there only a short time previously. That is not community participation. The people we need are those who are on the *receiving* end of both preventive and curative health services. Of course, technically

trained professionals are needed as well, but the actively interested residents of the community and nation will, in the long run, have far more influence than will the health professions upon the directions taken by a public health or medical care program and upon its success or failure.

Let me give you an example. In Nebraska a remarkable health educator, Miss Elin Anderson, has been working for four years among farm families to arouse consciousness of health needs. When her work began to be successful and to arouse public comment, it was criticized, through lack of understanding of its significance, by certain professions. Miss Anderson then arranged a meeting between a state-wide committee of farmers and a state-wide medical committee. What happened? The professional persons who had not lately been in rural areas said bluntly that there was no real need for change, no evidence that people did not have all the health services they required. When they had finished, the farmers began, and told of driving 60 miles to the hospital over muddy roads with a woman in labor, of the child who died because diphtheria immunization was not available, of the farmer whose leg was crushed by a tractor and who was reluctant to call a doctor because the cost would be \$45 for fee and mileage to that farm, and who finally did see a physician only after he had a hopeless infection. And so on. Facts like these gave the doctors a new conception of the importance of Miss Anderson's work.

You who know the strength of public opinion can easily predict the result: the profession was deeply impressed by realities of which its representatives had hardly been aware; the farmers asked for and got a state-wide joint health committee of farmers and doctors, with Miss Anderson as its secretary. And the

PUBLIC HEALTH NURSING

program of the committee continues.

This type of community participation in health planning is needed at all levels of government. There have been a few beginnings on the federal scene. The best known example in recent years was, of course, the National Health Conference of 1938. Currently, the Children's Bureau, the Public Health Service, and the Social Security Board all have advisory committees, some of which are broadly representative. The Farm Security Administration has numbers of county and state farmers' committees on health and medical care problems. But federal agencies still have far to go to equal the accomplishments of many communities in developing public participation. Yet this is needed as urgently in federal programs as elsewhere, and it is particularly needed now, when war

conditions have created many desperately serious health and medical care problems, as yet unsolved. I hope we may look forward soon to the establishment of a national health commission, set up to work with all federal agencies active in the health field, and composed of persons selected from within and outside of government, from the health professions, from labor, industry, agriculture, and other representative sections of our national community. We may expect to develop an adequate national health program, professionally sound yet socially broad and effective, only if we are able in some such way, on a *national* scale, to broaden the base of community participation in public health.

Presented at the morning session of meeting of Neighborhood Health Development, Inc., New York, N.Y., June 3, 1943.

NURSE PLACEMENT SERVICE

NPS announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom consent to publish these has been secured in each case from both nurse and employer.

PLACEMENTS

- *Gertrude Beattie, executive director, Visiting Nurse Association, Easton, Pa.
- *Norma Larson, field supervisor and educational director, Public Health and Visiting Nurse Association, Meriden, Conn.
- *Amy Erickson, instructor in nursing education, Department of Education, Indiana University, Bloomington, Ind.
- *Luella Olson, instructor of public health nursing, Protestant Episcopal Hospital, Philadelphia, Pa.
- Euphrasia A. Purrington, public health nurse,

*The N.O.P.H.N. files show that this nurse is a 1943 member.

- Binghamton City Hospital, Binghamton, N. Y.
- *Esther Lebens, orthopedic field nurse, University of Illinois, Division of Services for Crippled Children, Springfield, Ill.
- Mrs. Emily Passmore Nesbitt, public health nurse, Planned Parenthood League of Iowa, Des Moines, Iowa
- *Mrs. Mabel W. Corbett, county nurse, State Department of Public Health, Santa Fe, N. Mex.
- *Mrs. Sybel Parker Degnan, county nurse, City-county Health Unit, Great Falls, Mont.
- Mrs. Jessie I. King, school nurse, Forest Park Public Schools, Forest Park, Ill.
- Joan Emberland, school nurse, Board of School Trustees, Hammond, Ind.
- Mrs. Jane A. Hartmann, industrial nurse, Central Scientific Company, Chicago, Ill.
- Mrs. Violet W. Lind, industrial nurse, Container Corporation, Chicago, Ill.
- Mrs. Cornelia S. Lentini, industrial nurse, American Stove Company, Harvey, Ill.
- *Eleanor Lorenz, staff nurse, Northern Dutchess

(Continued on page 614)

Infantile Paralysis---1943

By DON W. GUDAKUNST, M.D.

THIS year there has been one of the most severe epidemics of infantile paralysis of the past quarter century. By the end of the first thirty-nine weeks 9,311 cases had been reported. There may well be over 11,000 cases during the twelve months of 1943—a number equalled only twice in the history of this disease in the United States.

As usual, the distribution of reported cases has been most spotty. California, Texas, Oklahoma, Illinois, and Kansas head the list. While all states have had at least a few cases reported only about twelve had anything approaching epidemics. The concentration of cases in epidemic areas has had both its advantages and disadvantages. On the plus side was the fact that skilled professional services could be utilized to greater advantage as larger groups of patients could be cared for under one roof; federal departments and national organizations needed to distribute their aid through only relatively few agencies; both medical care and epidemic research programs could be concentrated. On the negative side of the ledger were the facts that hospitalization facilities were inadequate in many places; only a few public health nursing agencies were prepared to assist; public fear at times turned to panic; the financial drain on local resources was excessive; local medical care tended either to break down or become so disrupted it was inadequate.

The problem of providing adequate medical services always is serious in such

outbreaks, but it is a task at which many are skilled and for which precedent has long been established. Securing medical care in epidemic areas was much less difficult than providing sufficient nursing and physical therapy services. Particularly was it difficult to provide physical therapists. All epidemics of poliomyelitis have brought forth the same problem to at least some degree, but this year the almost universal adoption of the Kenny method for treatment has magnified this many times over. There simply were not enough nurses and physical therapy technicians to care for the patients. Even the large cities, such as Chicago, San Francisco, Los Angeles, had the same difficulty. The task would have been hard enough with a treatment regime of immobilization. With the newer method calling for hot packs plus almost constant physical therapy from almost the onset of symptoms, the shortage of workers has been tremendously increased and emphasized.

The lack of nursing care was not a problem peculiar to this infantile paralysis outbreak. The same difficulty would have been created by any other epidemic calling for hundreds of thousands of additional days of nursing care all crowded into a comparatively few months.

The demand for physical therapy technicians, competent to administer the highly specialized services called for under the Kenny system, could not be met. Skilled physical therapy technicians always have played a most im-

PUBLIC HEALTH NURSING

portant role in the treatment of poliomyelitis, but in the past their services could have been distributed in a much more leisurely manner. In previous years each patient received far less physical therapy care and such care as was given was usually spread out over many months or even over a period of years. In most instances patients were not referred to technicians until from one to three months following the onset of their illness. To apply the newer methods calls for this type of service to be started almost immediately upon diagnosis and to be concentrated during the first few months of the illness with, it is hoped, comparatively less care given during the later periods.

This shift in treatment has similarly increased the burden on hospitals. In the past many cases would have had but a few weeks of initial hospital stay following the onset. Patients were then discharged to homes or convalescent wards to remain in splints or casts, or merely to rest in bed. Now the initial stay in hospitals under intensive treatment is usually much lengthened, the patient remaining in the hospital and receiving daily hot packs and physical therapy until maximum recovery has been attained. This has meant that in epidemic areas most of the reported cases were in the hospital at the same time, the first cases not being discharged until after the last of the epidemic was passed.

THESE problems have been difficult but by no means insurmountable. All communities with epidemics have done magnificently. The public, as well as the professions, have met the challenge. In hospital after hospital new uses were found for lay people, both those who were paid and those who volunteered their services. Nursing aides have not only

cut and prepared wool for hot packs, but hour after hour, day after day, for weeks and months they have wrung those packs out of the hot water. In many places they have done a magnificent job of actually applying them under a minimum of supervision from nurses and physical therapy technicians. These services have been in addition to the many services usually afforded by nursing aides and other volunteer workers.

The public has responded in still other ways. Old blankets and other woolen materials have come out of closets and attics to be donated to hospitals. Washing machines and wringers have been moved from laundry rooms and basements to these same hospitals—many times, it is suspected, at a real sacrifice and at the cost of much extra work in the home. Shower curtains and other waterproof fabrics have been donated, for all these were items on the scarcity lists. They could not be bought. More than money was needed to meet these epidemics.

Of course, money was needed, but money was not enough. No community could merely "buy" the medical care demanded for its poliomyelitis patients during these outbreaks. True, money could and did equip and prepare additional hospital beds in those many places where they were so badly needed. But nurses and physical therapy technicians could not be secured with money alone. The shortage was real. There was little or no unemployed reservoir upon which to draw. Every nurse, every physical therapist had to be taken away from some other important task to care for poliomyelitis patients. There were no new nurses or new physical therapy technicians to be hired, and there was not time enough to train new workers in these fields. They had to be borrowed.

THE BURDEN of supplying these workers to epidemic areas fell largely upon the National Foundation for Infantile Paralysis. Particularly was this true in respect to physical therapy technicians. In the relatively short time since the introduction of the Kenny method to this country intensive postgraduate training of two or more months had been given to about three hundred of these workers. Since almost all of them had secured this training with financial aid from the National Foundation their records were available to the Foundation. These were the key persons in the emergency epidemic aid program. The National Foundation knew not only the amount of graduate training of each worker, but knew something of her ability, knew her professional connections in her own home community. Workers were "borrowed" from non-epidemic communities, and with the cooperation of their employers—city, county, and state agencies, as well as hospitals and schools—were gladly loaned not to the National Foundation, but to hospitals and other agencies in epidemic areas. The National Foundation merely made all necessary arrangements, secured and paid for transportation, and when indicated paid salaries.

These workers at best could be borrowed for only relatively short periods of time, the average period being 60 days. It is to be emphasized these were not surplus workers, but in almost every instance key persons, many times in supervisory positions. It was often necessary to replace them with still other workers borrowed from still other non-epidemic areas. Only by such cooperation was it possible to provide even a semblance of the Kenny method of treatment to the many thousands of new patients reported during a short few months. Only an organization national in scope could have hoped to

have rendered this greatly needed service.

In addition to finding physical therapy technicians, supplies in the way of wool—over fifteen tons of it, dozens of respirators, washing machines, all have been sent to epidemic areas. The story of wool has been one of which the American people might well be proud. On the one hand, wool was more than expensive—it is one of the items made scarce by war; on the other hand, paper mills used a high-grade wool woven into large "felts." When these felts are no longer of service to this industry many, many valuable uses are found for them, the principal one of which ordinarily is to be cut into high-grade blankets. The American Paperboard Association has donated nearly fifteen tons of this valuable material to the National Foundation. The Foundation has had this cleaned, cut, sorted, and shipped to hospitals giving the Kenny treatment, at a cost to the community only of the express charges.

THESE are but some of the many programs carried on by the National Foundation on a broad scope during epidemic times. The chapters of the Foundation, serving more than 2900 counties, have rendered still other equally important services. It is these agencies that have paid for hospital care, provided nurses, paid the salaries of technicians borrowed by the National office. The chapters have paid the bills. Every patient with infantile paralysis has been provided, without delay, the best the community could secure in medical care and hospitalization. There was no question of age, color, legal residency, or other factors so frequently serving as a bar to medical care. The chapters in all epidemic areas were instructed to spend their money freely—but wisely. They were told to spend every cent of it if it was

PUBLIC HEALTH NURSING

needed. The officers of these chapters were told that if and when their funds were exhausted the National Foundation would advance to them all that was needed to assure adequate care for the poliomyelitis patients of their community. Chapter after chapter in many parts of the country has been able to do its full share because of this arrangement. In place after place all hospital care has been furnished by the chapter for all reported patients with funds advanced from the National office. During this epidemic, every demand was met.

Until some research worker, some epidemiologist, or some scientist finds the ultimate answer to the problem of how to prevent the spread of poliomyelitis, it will be necessary to lay plans against recurring epidemics. Every few years almost every community will be revisited by infantile paralysis. No community can peacefully ignore this possibility during the years of freedom from this crippling disease. This is why the National Foundation has established chapters in nearly all of the counties of the United States.

With a disease occurring at such infrequent and protracted intervals few communities can be expected to keep on hand all the things and all the persons needed during a major outbreak, but a certain minimum amount of preparation is essential. The outbreak of 1943 was not catastrophic in its effects largely because there had been such planning. Doctors,

nurses, and physical therapy technicians had been provided postgraduate training in the very latest methods of meeting the problems of this disease. At conferences of public health, medical, nursing, and hospital authorities plans had been made to care for expected patients. Iron lungs were taken from storage, tested, and repaired. Nurses were instructed in their use. Locations of other machines in other communities were ascertained, to be borrowed if need be. Money was collected in dimes and dollars at the annual celebration of the President's Birthday, half of which was retained by the local chapters. This was fluid money, readily available on a moment's notice to be spent in any manner that would best help the lot of the infantile paralysis patient.

LACKING any means of prevention, the health and medical authorities in cooperation with the voluntary agencies can plan for the best possible medical care, both during and following the epidemics which may descend unexpectedly and always unannounced. It is to the public health nurse that these authorities turn, both in their planning and in the execution of their plans. A large part of the burden of work in great epidemics of infantile paralysis, as in other communicable diseases, falls upon the nurse in public health. Therefore, it is well that she plan and plan carefully what must be done if epidemics do occur.

(N.P.S. Continued from page 610)
Community Nursing Service, Rhinebeck,
N. Y.

ASSISTED PLACEMENTS

*Mrs. Margaret Robertson, assistant professor and field supervisor in public health nursing, University of California, Los Angeles, Calif.

*Helen Fisk, assistant nurse instructor, State Department of Health, Baltimore, Md.

*Jane Taylor, consultant nurse-venereal disease, Kansas State Board of Health, Topeka, Kans.

*Hazel G. Barkley, junior nursing consultant, Pan American Sanitary Bureau, Washington, D.C.

*Kathryn E. Worrell, supervisor, Visiting Nurse Association, Los Angeles, Calif.

*Hettie Gooch, orthopedic nurse, Berrien County Society of Crippled Children, St. Joseph, Mich.

Health for Japanese Evacuees

By RUTH E. HUDSON, R.N.



I RECEIVED my U. S. Civil Service appointment to a Japanese Relocation Center as public health nurse in February of 1943 and arrived at my field in Colorado on the twenty-fourth of the month. After a four-day trip by auto I was tired, but my first impression of the Center was not to be a permanent one. I had been told that the Center resembled any other community of 7,000 population. However, I was, to say the least, unprepared for the first glimpse of the drab assembly of barracks stretched out on a sandy hill surrounded by prairie land, the spacious extent of which gave me a feeling of suffocation rather than the opposite impression which one would reasonably expect from "wide open spaces."

Added to this uneasy feeling I was depressed by the restricted atmosphere presented by a military guard and the routine of having to present a pass at the gate. This unhappy association lifted as time went on and the guards became friends who waved me on my way or

checked my readmittance with a cheerful "Good night."

My first impression of the Japanese people was that of having the peculiarly unpleasant feeling of being laughed at, or rather the uncertain experience of not knowing just what is the amusing angle and thinking that it might be I. I came to find out that, as individuals, Japanese-Americans can be brought readily to the happier experience of laughing with you, and by so doing in no way "lose face."

THE physical setup resembles that of almost any army camp. The area is one mile square with rows of residence barracks arranged in 30 blocks, criss-crossed by streets which lead into the administration and hospital areas. In the administration area a section is set aside for resident appointed personnel. The hospital is located at the extreme right of the Center and consists of 17 wings connected by a catwalk. At the extreme front there is the military area where "Old

PUBLIC HEALTH NURSING

Glory" in all its reassuring grandeur waves against the blue, blue sky.

Residence barracks in general consist of one-room apartments, each housing a whole family unless it is too numerous. In this situation an additional one or two rooms is allowed. Each block of barracks has a mess hall and a recreation hall, the latter for movies, local talent plays and business meetings. Some apartments are used for shops such as shoe repair shops and the "Canteen" (all of these are operated on a cooperative plan). One hall in each area is set aside for religious worship for the followers of each group represented. The Protestant and the Buddhist groups predominate, and there are about 60 families of the Catholic faith. One entire block is set aside for schools—elementary, junior and high schools and a few adult education classes. The regular enrollment is about 30 percent of the population.

The 7,000 Japanese men, women and children of the Center have been evacuated from the Pacific Coast area. The appointed personnel are some 200 Caucasians who act as department administrators. The project director is assisted in governmental matters by an evacuee representative from each block.

The hospital is headed by a chief medical officer who also acts as health officer. The nurses—Caucasian and evacuee—work under the direction of a chief nurse. Nurse's aides, orderlies, janitors, diet kitchen workers, all have been recruited from among the evacuees and trained by appointed personnel. The hospital has 150 beds and is equipped to take care of any emergency.

The entire medical service is provided by a staff of five evacuee physicians, who not only provide hospital care, but have a well-established outside dispensary service, with special clinics. It was with these special clinics in mind that I began

organizing a number of general public health activities.

HOWEVER, due to circumstances existing at the time of my arrival, I was designated by the Chief Medical Officer to take the position of Acting Chief Nurse. This experience, however confusing at the time, proved very valuable as it gave me the chance to become well acquainted with the entire setup from the inside out.

The opening of a new isolation unit of the hospital brought me in close contact with evacuee personnel as well as with patients. In recruiting workers I began my education in pronouncing as well as spelling Japanese names.

Our entire contagious disease problem at the time consisted of 10 tuberculosis cases. I came to know that tuberculosis, and not venereal disease, is regarded by the Japanese as their "social disease." This was brought out by the difficulty which we had in obtaining nurse's aides, orderlies, and even janitors for the newly-opened unit. The entire populace fears tuberculosis and any association with it. It seems that years ago in Japan a very dramatic book was written which stamped tuberculosis as a disease of disgrace even to the extent that it presents a barrier to marriage into a family which has even a remote history of the disease. This attitude causes people to be secretive about infection—a tendency which results in cases not being found until it is too late to effect a cure.

As Acting Chief Nurse I was brought into close contact with the special clinics I have already mentioned as presenting a possible beginning for a public health program. I became well acquainted with the mechanical organization of the Center Hospital as related to the associated departments such as public welfare, social service, and the Center at large. I had an opportunity to work toward setting

JAPANESE EVACUEES

up a program which would interest all the nurses and doctors from a public health point of view. At the same time, I began, with the cooperation of the business manager of the hospital, to recruit public health aides as well as clerical help.

AT THE time I was Acting Chief Nurse I was also establishing a Public Health Office in the administration area of the hospital. I began conferring with various evacuee people in key positions throughout the Center—the president of the Federated Women's Clubs, the secretary of the Y.W.C.A., the boy scout master, and the hospital chaplain. I also spent some time with school personnel. I visited the nursery schools and became acquainted with the evacuee supervisor who is a person of real ability and keen insight into the problems of her people. I visited the first aid station at the school and gave suggestions where indicated.

These people, each in his own sphere, gave me insight into some of the problems of the Center. One told me of the poor dietary habits of the race and asked for a re-educational program in nutrition. Another was concerned about the lack of sex instruction of adolescent boys and girls and pointed out the barrier which often exists between parents and children in the family group, not only because of race teachings but also because neither speaks the other's language.

This language problem presented a handicap in the organization of my own department. However, after selecting a staff, I found that I had very wisely included both Japanese-speaking workers as well as one who could speak both languages. I found it difficult to make myself understood and I came to see that the only sure way was to rely on the aid of an interpreter. Now I never give instruction to my Japanese-speaking aide unless my other aide is present "to make

myself clear." So far, my own understanding of Japanese is limited to one word which sounds something like "Hi" and means "Yes"—or is it "No"?

One of the outstanding problems of the Center was to organize a method of distribution of baby foods: cereal, canned milk, eggs, oranges. This distribution was done through stations located in the barracks. Girl station attendants worked under the direction of an evacuee registered nurse who had become quite ill. At the time I came the entire situation had got more or less out of hand. The attendants had very little authority with the people in the blocks. No one knew just how many babies there were or of what ages. There was some doubt as to whether the food was being consumed by the babies or some other member of the family. There was very little established routine.

After some discussion it was decided to place this project under the supervision of the public health nurse. For the first time in my public health experience I had the opportunity to supervise the selection and administration of a proper diet for babies and preschool children. This responsibility called for more organization and more recruiting of personnel.

An English-speaking group was desirable for this purpose, and one which could also speak as well as understand Japanese. They needed to be dependable and active and interested to the extent that the program would gain the confidence and good will of the public. I felt that I had to work carefully, as a step in the wrong direction might very well upset the entire program.

ALL RELATED personnel gave wholehearted support. My first recruit was a young girl who had had some work in the nutrition field. Because of her frank facing of current problems, she proved



The Granada Project of the War Relocation Authority, Amache, Colorado

invaluable in recruiting the aides and helping to organize the undertaking. With this girl as nutrition aide supervisor, I began recruiting nutrition aides for the various baby food stations which we now planned to re-establish, this time in the mess halls.

A deluge of applications surprised us and from these we selected a group of 14 well-educated women, most of whom were mothers of preschool children and lived in or near the blocks where they were employed.

Conferences were held in which problems were freely discussed. Each new aide was given definite instructions and limitations were pointed out as to her authority as well as her obligations to her position and to the babies under her care. It was also made clear that the authority of the department was behind every aide in the field. Weekly conferences were scheduled to study child care and feeding.

The nutrition aide supervisor keeps in close touch with the girls in the stations.

We have a complete card index of all babies up to three years, and a definite routine for feeding is worked out for children of all ages. The local paper which has helped in other projects to get information to the public also cooperated in this program.

These aides are continuously on the lookout for any problem which might be even remotely related to public health and to the smooth running of the organization as a whole. The mothers have come to depend on them and the children love their "kitchen mamas."

OUR "library," consisting mostly of free material, is in most cases adequate. By loaning rather than giving it away, we stretch our supply. To be sure, some money was spent for tuberculosis booklets as we felt there was a need here for wide and speedy dissemination of information. By the loan method we find that mothers appreciate the literature more and also that by keeping it in circu-

lation we have created greater general interest in health literature.

There is generally at least one English-speaking member of a family who can read and interpret for the others, or again the nutrition aide in the block performs this very necessary service.

Relieved of my duties as Acting Chief Nurse by the arrival of a government appointee, I turned my attention to the special clinic setup.

OBSERVATION revealed that the "Well Baby Clinic" was more or less a treatment clinic, and the interviews with mothers were not being conducted after accepted public health patterns. This was apparently due to the fact that the doctor in charge was not especially interested in well baby care.

After careful planning with department administration officers I began the organization of the entire Center in districts, each of which would have a typical child health conference. The complete file of all babies and preschool children was divided into four groups and conferences with each group were scheduled for consecutive Tuesdays to be held at a centrally located recreation hall in each of the four districts.

Twenty-five appointments were sent out to be distributed by the nutrition aides. Twenty-eight mothers and two fathers came to the first conference. The nutrition aides were present to assist in weighing and measuring babies and to act as interpreters. The public health aides set up the clinic. We had not been able to obtain the services of a doctor so the nurse had to officiate. Feeding problems, behavior habits, and the institution of new schedules were discussed with each parent.

This plan has been carried out throughout the Center and interest has been so marked that in two districts we have had

to hold another conference later in the week. The baby clinic at the hospital is still in operation and any child indicating the need for a physical check-up is referred to the doctor there. Immunizations are also given at the hospital. The success of the child health conference is demonstrated by the monthly attendance—165 on the average as compared with 25 in the treatment clinic.

In general Japanese-American mothers are neat and clean and keep their children likewise. Our big problem is to convince mothers to wean their babies at the right time, and in the older generation group, to teach them that lots of rice is not good for babies.

In the beginning, working in the prenatal clinic as it was already set up seemed best and therefore a conference room was arranged in which to interview each patient before she leaves the clinic. Information is given regarding care for the mother and preparation for the new baby. An effort is made to understand the family as a whole. Various family problems are considered such as the special needs of women whose husbands have gone out of the camp to work. Mothers are advised to take advantage of the opportunity afforded by the coming of a new baby to give sex instruction to the younger children.

An effort has been made to follow through on other special clinics as well. Patients and contacts are followed up in the home and a start has been made in an educational way on a tuberculosis program. The picture, "They Do Come Back," from the National Tuberculosis Association was used to good advantage. One evacuee doctor is interested in health education, and the registered Caucasian nurse in charge of the hospital unit is most cooperative. Much of the various routines in the hospital have a definite carry-over value to the public.

PUBLIC HEALTH NURSING

I began the school health program by attending a meeting of all principals and outlining for them the assistance we could offer. We discussed the need for the school teachers' taking the lead in the program, also the incorporation of health teaching in school work. Plans were made for demonstration of routine morning inspections which were henceforth to be carried out in the schools.

It was planned that the first aid stations should refer children to the hospital for dental correction and eye examination. A trained first aid attendant is present at all times to care for simple injuries which do not need to come to the hospital.

A plan was worked out whereby teachers may refer any child to the general clinic for a physical examination if indicated.

As public health nurse, I have been asked to serve on various committees in the interest of health problems. These have included the Public Affairs Committee, the Committee for the Study of Nutrition Problems of Children as related to the community mess hall feeding plan. My participation in all community activities has helped to build confidence in the public health program. Contact with the county as well as with the state health department has helped in many ways. Our Crippled Children's Clinic is an example of what the State Department of Health has done for us. State supervisors have aided with encouragement and suggestions.

THIS is a rather brief summary of what has been and continues to be a very interesting and unique experience. Not all has been work. There are times of relaxation and fun. Any time you put a group of nurses under one roof you will have times of frivolity and sessions of letting the hair down. We are no exception.

Our quarters are comfortably located in a wing of the hospital. We have a spacious lounge at the end. The wash-room is at the center of the wing and has rows of wash basins on one side, bathtubs on the other, and a bunch of "johnnies" across one end.

Our most hilarious times have been on nights when the sudden dousing of the electricity called forth a dramatic raid on the icebox. Garbed in nightgowns and carrying small candles stuck in tea cups, we presented a ghostly picture. We also have our excursions to the nearest town which is 16 miles away. There we go to a movie or eat ice cream in the very nice air-conditioned coffee shop.

These things I have learned:

1. The advantage of having the public health office located in the hospital and operating as a part of its whole teaching program.
2. The importance of having lay workers in the field, placed there with specified duties and simple instruction and governed by specific limitations.
3. The value of establishing a record system which is not only clear to all workers but requires little time and effort.
4. The importance, in working with another race, of objective leadership—leading from the background, thus giving the evacuee a sense of pride in accomplishment.
5. The value of taking the long view of the department's organization and contemplating vacancies before they occur, giving it an equilibrium which the relocation of a few does not disturb.
6. Through simplifying my objectives and analyzing my work and my relationship to my profession, the significance which I as a public health nurse have to all people and the importance which my interpretation of health has as a force for good.

Helping Board Members to Make Their Greatest Contribution

By MARGUERITE PRINDIVILLE, R.N.

NOW WHEN we are in the midst of a struggle to preserve our democratic way of life, public health nurses should look carefully at their responsibilities as professional leaders. The nursing agency needs the help of citizens. Recognizing this fact we have shared our responsibility with lay groups more or less effectively in the past. However, scientific tools have been given us far more rapidly than we have found the means of applying them. When the citizen knows something about them, his participation in the group which is shaping the aims and policies will bring about greater and faster universal application of these tools.

We frequently hear the comment, "We must make our Board of Directors meetings interesting." Our program is weak if this is necessary because it means that members of the board have not been helped to grasp their particular function in the program, nor to accept the responsibility entrusted them by their membership. Too often a nurse responds to the wishes of a few board members who merely expect the reports of the nurse to entertain them, rather than give them the knowledge and comprehension they need to fulfill the strategic role they play. Board members' interest will grow only as they can join in group deliberation about important matters and feel they really contribute. Because the board of direc-

tors in a public health nursing agency is responsible for administering the organization, the program of public health nursing becomes a shared experience between professional workers and lay members.

It is inconceivable that the two groups will participate equally well when one group is prepared and the other is not. Who then must prepare board members? The public health nurse acts as expert and guide, but only when board members take an active part do they make their greatest contribution. It is, of course, essential that the nurse bring to a discussion at a meeting of lay people the facts that interpret all sides of the problem, but merely because of her familiarity with the field, she is not privileged to dominate the discussion and impose her own will. The group needs full opportunity for thinking and planning.

AIMS IN BOARD PREPARATION

The nurse will find that the guidance she offers at board meetings does not greatly differ in principle from the guidance she gives her staff or patients. All the methods of teaching with which she is familiar will be of use in the help she can give to board and committee members.

1. Her first step will be to analyze the group. She can find out how well her lay people are informed about the subject and start from that point. In some

PUBLIC HEALTH NURSING

communities, board and committee members may be completely unaware of community health work. In others they will be extremely well informed, having given much study to the subject. In some communities, they may be both uninformed and misinformed.

As in a staff education program, the nurse director can discover, mostly by interview, how complete is lay directors' understanding of health problems. The nurse, if she views board preparation as a tool in furthering public health, will consider individual differences just as she does with her staff. If there are both men and women on her board, her program of information will include facts for both groups. Usually what impresses the executive or merchant who pays the taxes will not appeal to his wife who is interested primarily in humanitarian problems. It will also help the nurse to find out what led her group individually to become board members. Some may have a deep interest in health work because of some past experience; others because of visions of future development. Still other board members may know nothing about health problems of the community, but wish to serve as a civic duty because they can bring business judgment to the program. The motivation of each individual will guide the nurse. Each board member has his own peculiar value in the collective thinking, according to his past experience and his new health knowledge.

2. Another point to be considered in preparing the group is the educational program plan. This will depend on the length of time the board member serves. A rotating board necessarily calls for a more concentrated development than a stationary board. The spread of health knowledge is greater in a rotating board, but with the limit of time, the nurse must

plan carefully so that each member obtains the necessary information in time to be of use.

3. As in solving any educational problem the nurse will find it essential to state her aim and what it is hoped to accomplish. Surely our aim in board preparation is to help each member obtain sound scientific knowledge as necessary equipment for citizenship service in public health and for fulfilling the purpose of the agency.

To accomplish this purpose, manuals and other health literature, interviews and projects will be useful but probably the nurse will find her greatest opportunity through her reports at regular board meetings. The following general topics provide a convenient outline for presenting her material:

1. Administration
2. Staff guidance
3. Community activities
4. National interest in public health on a local level.

In compiling her report the nurse can use all her skills. Readiness of the student is one of the first factors to consider. Fortunately we seldom have to create a readiness in teaching health because it is already a vital factor in every individual life. One other great aid today creates a state of readiness—international and national discussions about public health are frequently reported in magazines and newspapers. It will be helpful to take these national topics and restate their principles as they apply to the local situation.

Charts and graphs are useful means to the end of successful interpretation. These need not necessarily be made by the director. She can draw upon community resources such as the schools, Junior League, talented staff members, or she can substitute posters made with maga-

BOARD MEMBERS' CONTRIBUTION

zine pictures. Artistic skill is not so necessary as resourcefulness.

ADMINISTRATION

Innumerable administrative problems needing group deliberation arise in the conduct of any agency. The nurse director's responsibility is to present clearly the facts about these problems to her board. She is privileged to point out good public health procedure but she must also present all aspects of the problems. But first board members need an introduction to the agency.

The Public Health Nursing Organization of Eastchester has found it helpful to have the first board meeting of the year an orientation meeting, when the director defines public health nursing and briefly covers the purpose of the organization as stated in the articles of incorporation. She outlines the number of nurses on the staff, personnel policies, and financial support, including a discussion of fees and their adjustment. Contracts with agencies and insurance companies are explained. Public health nursing terminology is made clear. Records and statistics are our best means of measurement of service and these can be made most interesting. At this first meeting board members will appreciate an explanation of how to read the monthly nursing report. The director can, by means of a graph, show community relationship with the medical advisory committee, the nursing council, and other agencies. This is the time to give each new member a "board manual" with reprints of agency material, such as its history and by-laws.*

Trends of the agency program create administrative problems which necessi-

*Samples of board manuals and revised suggestions for issuing a manual are available from the NOPHN.

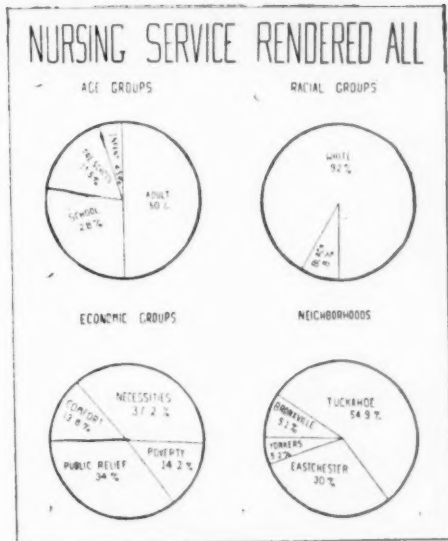


Figure 1

tate board decision, for example, changes in volume of work. Here a chart can demonstrate effectively, whereas a verbal statement might be confusing. Clearly drawn lines or bars can show the number of cases carried or visits made in one year as compared to those made in another year, or the total amount of service and the various types of service to the community. Symbols, or simple drawings to illustrate bedside nursing, health education, or clinic service add variety. It is very important for the board to understand that public health nursing is democratic. Service is given according to need of patient regardless of economic condition, race, or age. Figure 1 shows one way to make this fact impressive.

Financial support for the organization is a responsibility keenly felt by board members. This might be the topic for one meeting. A graph showing the trend of pay visits would provoke discussion, or one comparing the local agency with other communities, both locally and nationally, in the percentage of pay visits. When

PUBLIC HEALTH NURSING

the Eastchester organization combined its program with the Westchester County Health Department, so that its budget included both private and tax funds, it was necessary that there be a clear understanding of how costs were to be assumed. A chart using simple outlines of various articles, such as a telephone, a house, a nurse's bag, to depict that portion of the cost which was assumed by each agency, made this explanation clear and acceptable.

STAFF GUIDANCE

Board members feel a keen responsibility for the quality of service rendered by their agency. Quality of service depends upon quality of personnel. The director can stimulate board members' interest in nurse education on a national scale as well as in the local staff educational program. A meeting might be devoted to a comparison of academic and professional qualifications of the nurses on their staff with the qualifications recommended by the national organization. The director can explain the philosophy of democratic supervision and how it is carried out by such means as field visits and record reviewing. This discussion can also deal with personnel policies. By means of a chart, differences in salaries, locally and nationally, can be made vivid, also problems of hours of work, visits made per nurse, and many other situations often needing study. Only if the board has a complete understanding and knowledge of staff qualifications can it bring about any needed change.

COMMUNITY ACTIVITIES

The board expects the nurse director to keep them informed as to the health needs of the community. One way of doing this is by applying national trends as expressed at conventions and in current

public health literature to the local situation. Special speakers may be invited to talk at board meetings. When the nurse talks with groups such as PTA's, church groups, or other clubs, she should report their reactions, their questions and challenges back to the board. It is important to note economic changes in a given area. A chart showing services rendered to the various economic groups as noted on the nurses' records can help interpret these changes. Right now the nurse needs to interpret changes in service already caused by the war and to prepare the board for further study and any possible change that may be necessary, such as reduction in staff and service. The board will want to know how far such a reduction can be made before minimum safety is threatened.

The health problems of specific racial groups are of general interest. Some citizens will be surprised to learn that the high death rates of any group present a hazard to everybody. In presenting this information it will be helpful to have a chart showing comparative death rates of racial groups. Research may be necessary before the director can point out what factors cause these differences in death rates and what citizens can do to help correct them.

LOCAL VS. NATIONAL HEALTH

In the interpretation of community as compared with national health the nurse will find another stimulating topic for discussion. National planning cannot be effective unless every town and village has the vision to see itself as a part of the national public health program. The report of the National Health Survey of 1935-36 can be used as the basis for an explanation of the agency's morbidity service. Local disease and death rates should be compared with national rates.

BOARD MEMBERS' CONTRIBUTION

The cost of taking care of as compared with the cost of preventing incapacitating diseases is of interest to citizens who must pay these costs either through public care or the general economic loss due to disease.

A public health nursing program extends into new fields of public health such as the industrial or nutrition. A nurse director must be prepared to introduce her board to new needs, using all available sources of information. Much of her data will come from national organizations.

The communicable disease program always especially interests board members. Its problems are usually clear-cut and the results of prevention and treatment efforts easily measurable. Then, too, communicable diseases are more apt to strike nearer home as they respect neither geographical nor economic boundaries.

In presenting to the board the wealth of material about preventive nursing the director can utilize effectively both generalized scientific facts and human interest case stories.

Facts give breadth and vision to the

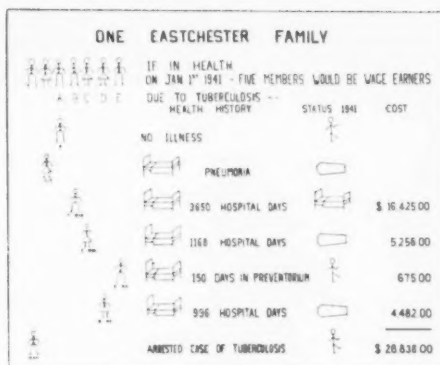


Figure 2

aims of the program and show the goals and measuring rods for our work essential to those planning for the greater good of the community. Human interest stories can illustrate broad principles. A chart showing the continued improvement of the diphtheria immunization of preschool children in the community will tell a great deal to those who are trying to control epidemics. The case story approach in a chart showing the cost of an illness such as tuberculosis will especially

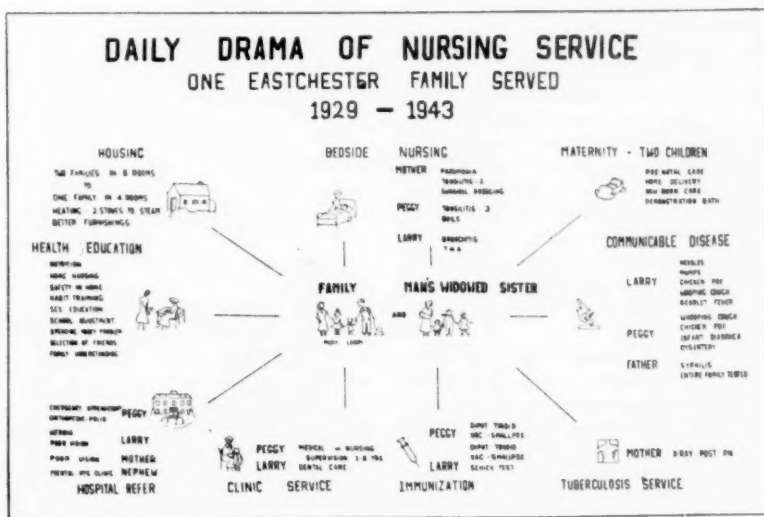


Figure 3

PUBLIC HEALTH NURSING

appeal to members of the board who are concerned with national economic loss due to illness. Such a chart as Figure 2 gives information as to the diagnostic and nursing service available in the community. It makes clear the value of early case finding. It not only emphasizes that tuberculosis is a communicable disease but that it is a serious economic problem wherever it strikes.

Figure 3 portrays complete service to one family and emphasizes the public health nursing philosophy of working with the individual, his family and the community. This illustrates the content and value of a generalized public health nursing program.

ACCOMPLISHMENT

Every teacher wishes to evaluate her work from time to time. In preparing board members we can easily use the progress of our program as a measuring rod. We need only ask how do the standards and policies of the organization meet national standards, what pioneering tasks have been undertaken, how flexible has the organization been and how courageous in new trends, what has the board of directors accomplished in securing funds for the work. Clear and analytical interpretation of public health nursing efforts can arouse the citizens of a community to interested action and support in public health.

Comments on "Helping Board Members to Make Their Greatest Contribution"

MISS PRINDIVILLE has suggested a most comprehensive general information program as the nurse's part in helping board members to participate more effectively. Now what is to be the board member's part?

Because a program of public health nursing is—or should be—a shared experience between professional workers and lay members, it seems to me there should be equal initiative and responsibility for the preparation for the job. Board members should not be satisfied with the routine introduction to the organization generally given but must realize how important it is to keep informed about changing resources and trends. Unless board members are aware of and want to learn about those trends, the most carefully prepared education program can be a total loss.

We board members expect the nurses to know the latest and best procedures, but do we require as much from ourselves in our qualifications for our jobs? Do we assume that because we have been on the board for a number of years, have had background experience in some professional field, are well established in the community or are regular in attendance at

meetings, that there is no need for us to keep abreast of public health nursing progress throughout the country and thus be able to parallel in our administrative duties the professional progress?

By all means, we should want an education program, but for two reasons I should like to see it be a joint project of lay and professional people.

First, when professional time is at such a premium and we are all trying to have it used more productively, it seems inconsistent to let a nurse spend hours, most likely hours which should be hers for relaxation, making charts and preparing statements in popular form for her board.

Second, whatever we do toward this board education program will have to be under the direct supervision of a nurse, but as board members we will have a greater interest, feel more responsibility, and learn much more if we do the research necessary to bring together the facts and figures. This is along the line of one good principle of teaching that is to help students to "learn by doing," which Miss Prindiville seems to have left out.

BOARD MEMBERS' CONTRIBUTION

No organization is too small or too large to have an education committee. Under the guidance of the nurses, this committee can allocate projects which will enlist the entire personnel of the board in a study program. Such a committee has unlimited possibilities of stimulating continuous interest in public health nursing at the national level and in this way of working with the public health nurse in "helping board members to make their greatest contribution."

HELEN J. ROLFE, 3RD VICE-PRESIDENT,
THE VISITING NURSE ASSOCIATION
OF NEW HAVEN (CONN.)

IN COMMENTING ON Miss Prindville's well-developed article on "Helping Board Members to Make Their Greatest Contribution," I am afflicted with the usual jitters experienced by the volunteer when faced with the trained point of view of the professional. On the other hand, I feel that too often professional directors feel that they must pamper the lay participants. In so doing they not only decrease the potential value of the volunteers, but also lessen the satisfactions which the volunteers may derive from having made a helpful contribution.

Two points I believe need greater emphasis are: (1) the selection of board members and (2) periodic evaluation, both of the program itself and of the work of the volunteers, individually and collectively.

As to selection of board members, I can see their functions divided into three parts: administrative, interpretative, and program. Certainly any board member's value is increased if his or her chief duties are within the realm of his chief interest and ability. The responsibility of the nominating committee is too often underestimated, too often assumed to be merely the suggesting of names of people willing to act as board members. Perhaps the fullest effectiveness of a nominating committee presupposes a program planning and reviewing committee who are continuously studying the trends and needs of the community and the degree to which the local association is in line with these. This committee would be able to make intelligent recommendations to the nominating committee as to the type of representation needed on the board and committees at that particular time, leaving the nominating committee the responsibility of finding the best person to fill that need. Many times there is a tendency to invite Mrs. Top Hat to become a member of a board, her

contribution to be chiefly prestige. We all fully appreciate the value of such prestige, but we must also realize that Mrs. T. H. is going to be asked many questions about her new alliance. Her only value is completely lost unless she can give a clear and intelligent interpretation of the organization. This means training, and I firmly believe that one responsibility of board membership should be attendance at a training institute of some sort—perhaps an annual all-day conference, at which the complete program is presented in detail, including both administrative and service aspects. I already can hear the groans of professional staff members across the country as they picture the organizational details of such an institute. But, as a volunteer, I can assure them that the stimulation of such a meeting would increase the value of their volunteers. Who knows? Perhaps the staffs themselves would receive some stimulation, too!

As to evaluation, this same program planning committee, in looking at the work of the organization as a whole, concerned with the smooth interplay of the various functions, can establish goals and emphases for any given period, against which the accomplishments of the lay and professional groups can be measured at the end of such period. The professional staff has the satisfaction of seeing concrete results of its work—increasing growth of the service, restoration of health to patients, improvement of personnel standards, and other accomplishments. But such definite effects of the volunteer's work are invisible to the volunteer. Therefore, I believe that an important part of a director's leadership talents should be employed in seeing that each volunteer is placed where his ability and interest will make him of greatest value, thus producing for him the corresponding satisfaction of having done a good job.

A public health nursing program has all the elements a publicity person cries for—indispensability, emotion and glamor, so a well-directed local organization need never lack for the highest quality in its board membership. Likewise, a well-directed program needs no build-up to retain the interest of its board members. Just give the volunteer a job in which he will feel himself a real part of this important element of today's social organization!

PAULINE SPAULDING
MEMBER, BOARD OF DIRECTORS,
LOS ANGELES VISITING NURSE ASSOCIATION

A Staff Builds Its Own Organization

By KATHERINE KING BAKER, R.N.

THE POLITICAL vicissitudes of San Antonio have more than once made "front page" reading outside the State of Texas. One such occasion was in June 1939 when a new mayor, after the usual procedure of hiring and firing, electrified the community by his reckless importation of a few outsiders, dubbed "foreigners" in the local press.

No part of the city government was more disturbed by these changes than the Health Department. In an atmosphere of tension and gloom, a group of fourteen nurses tried to maintain a semblance of organized service after the overnight dismissal of nearly half the former staff. During a three-week period they witnessed the departure of practically all the administrative personnel. It mattered little who resigned or who was discharged; the fact remained old friends were leaving and newcomers were taking their place.

To the group of retained nurses, none of whom had special training in public health nursing, a complete stranger was introduced with the brief statement, "This is your Supervisor." For both supervisor and staff, that was a critical moment. We laugh over the incident now; but we know the sympathy we felt for each other at our first meeting made a good beginning for our long hard pull together. Assurance of complete freedom from political interference has given us the courage to experiment; so we have pursued a somewhat adventurous course.

FACING FACTS

The new mayor had promised the city an efficient health department at an annual cost of \$125,000 which represented a rate of slightly less than 50 cents per capita. Apparently unaware of the authoritative estimate of \$1 per capita for minimum public health services, both the mayor and the citizenry expected the campaign promise to be fulfilled. The Health Department, which under the City Charter is relegated to the position of a subdivision of the Mayor's Department, was "on the spot." We of the public health nursing service knew we were expected to produce tangible results as quickly as possible. Together we studied our situation.

The racial composition of population was roughly 12 percent Negro, 43 percent Mexican, and 45 percent Other White—the last two groups being differentiated locally by the terms "Latin-American" and "Anglo-American." Over three fourths of the Mexicans were in the low-income or destitute group. For the city as a whole we knew the infant mortality and stillbirth rates were very high, and the maternal death rate higher than the national average. The one hundred or more Mexican midwives practicing in the city we considered a causal factor in these high rates. We knew the city had a significantly large venereal disease problem, and the highest tuberculosis death rate of any city in the nation.

BUILDING AN ORGANIZATION

Looking for related services in the community, we faced these discouraging facts: there was no council of social agencies, no community chest, no tax-supported relief. There was, however, a multiplicity of small private agencies connected by one bright hopeful link—the Central Index.

Except for a few nurses employed by the Board of Education to work exclusively in the public school system, the City Health Department nurses provided the only public health nursing service in the community. The Department's venereal disease clinic had to have three nurses; the tuberculosis clinic, two. This left only nine nurses (seven white and two Negro), all lacking special preparation in public health, to shoulder the burden of demonstrating effective public health nursing in a community of nearly 255,000 population. This aggregation of problems and handicaps (from the first we could substitute the word "challenge" for "problem") supported a foregone conclusion—the city's first and greatest need was community education.

Our objectives took shape coincident with our increasing recognition of the colossal nature of the job ahead. Our long-range objective was to participate in community education to the end that an enlightened public would demand adequate provision of the services necessary for effectively dealing with the city's many health and social problems.

To achieve this we needed a staff of resourceful, well-informed, articulate, capable public health nurses who could be convincing representatives of the Health Department. This obvious need defined our immediate objectives which were: to encourage self-government for its contribution to maximum individual development within organizational limits; carry on intensive in-service training; to organize our service from the standpoint of

efficiency and economy; develop a statistical service within our own division; cooperate as fully as possible with other agencies; and cultivate the greatest possible degree of flexibility in our service so that no opportunity for individual development or for improvement or extension of service would be lost.

It is not the purpose of this article to give a history of our organization during the past four years. It is true that during this time our staff has more than doubled, and several members have received special training through federal scholarships. Rather, it is our intention to indicate the manner in which an originally small group of sincere, eager nurses have worked together and with workers in other agencies toward their major objective of awakening a community to the value and necessity of adequate public health and welfare services.

SELF-GOVERNMENT

Before the end of the first week under the new regime, staff rule had been initiated. It came about in this way: when the newcomer first met the staff, she was wearing a blue uniform but the staff nurses were in gray. An inquiry as to where the gray uniform could be purchased was countered by a general request for a change from gray to blue. Immediately the staff was asked to select their own committee to consider the question of uniforms and submit their recommendations for staff decision. Since that day the staff has carried full responsibility for determining uniform regulations—the requirements and prohibitions being very few. Ample leeway is given for expression of personality and exercise of judgment. So long as the hat is simple and navy blue, it may be whatever shape or style the wearer chooses. The dress must be navy with plain white collar, "shirt-waist" design; all else is a matter of

individual choice. The important thing, in the opinion of the staff, is for each nurse to appear an attractive, self-confident individual.

With few exceptions the staff has participated in all policy-making. Likewise, our procedures reflect majority opinion or preference. The staff decided what should be carried in the nursing bag and how it should be arranged. Their decisions were made after study and discussion of the experience of others. Once made, there followed proud observance of "our bag technique."

IN-SERVICE TRAINING

At the outset it was recognized we could not do effective public health nursing without the necessary educational equipment. During the first year we experimented with all kinds of staff education activities. We spent what some might call "a scandalous amount of tax-paid time" on in-service training; but we spent time to save time later.

Every nurse was provided with a copy of the NOPHN *Manual of Public Health Nursing*, Louise Zabriskie's *Mother and Baby Care in Pictures* and the U. S. Public Health Service pamphlet, *Control of Communicable Diseases* (published also by the American Public Health Association in 1940 and 1943).

A library was started with a gift of several books from the local tuberculosis association. We added professional periodicals and well-known texts on venereal disease, communicable disease, nutrition, public health and public health nursing. We set up a reference file by subject and title.

Occasionally there were required readings. But generally the staff preferred that reading and study should grow out of rotating responsibility for book and journal reviews, and the necessary preparation for panel and round-table discus-

sions, public talks and organized classes. As might be expected, some members of the staff thirsted for knowledge more than others. To inject a little of the competitive spirit as well as experience in self-evaluation, we tried a few objective type tests on assigned chapters in the NOPHN *Manual*. Gradually (our observers said "rapidly"), the student attitude asserted itself. Increasing knowledge and ability in verbal expression were not enough. Through discussions on record writing, the staff recognized their need for improvement in written expression. For practice in writing, everyone was required to write a monthly narrative report summarizing her progress, problems and plans; also a case study on a family carried two months or longer. In 1941, when a local radio station requested regular weekly broadcasts on maternal and child health, the nurses were ready to accept rotating responsibility for writing and presenting these broadcasts.

There was the usual study of related activities. We had to know other services of the health department before we could interpret them; we had to know the resources of the community before we could use them. Field trips were arranged with meat, milk, food inspectors and general sanitarians; and visits to other health and social agencies. Division chiefs in the Department and other agency representatives attended some of our staff conferences to discuss their programs.

This much staff education we were able to do by ourselves. Wanting more, we requested help from other sources. Local physicians aided with lectures on obstetrics, pediatrics, tuberculosis and venereal diseases. Institutes were provided by such agencies as the State Health Department, Crippled Children's Division of the State Department of Education, County Tuberculosis Association and Red Cross.

Throughout our first year we needed additional supervisory service even though an assistant supervisor had been added to the staff. Frequently we requested and got supervisory help from the State Health Department. We persuaded the State Tuberculosis Association to give us two months of specialized supervisory service. We even successfully importuned the Red Cross for supervisory assistance in developing our group-teaching service.

Another valuable contribution to our in-service training came through a request that we provide instruction in personal and community hygiene and elementary home nursing for workers on the WPA Housekeeping Aide Project. We agreed to supply the desired instruction, but in turn requested the administrative personnel of the project, among whom were well-trained, experienced teachers in home economics, to help us improve our teaching methods. This arrangement proved so satisfactory, it continued until the project closed in December 1942. With this initial experience, we extended our teaching service to include organized instruction for midwives and for expectant mothers. Later we added group teaching in our maternity clinics, well-baby conferences and tuberculosis clinic.

ORGANIZATION OF SERVICE

Probably the most difficult adjustment some members of the staff had to make was the almost immediate change from a specialized to a generalized service, but they were "willing to give it a try." The staff was asked to decide on the boundary lines of the nursing districts into which we divided the city. The satisfaction growing out of full responsibility for service within a given area made zealous generalists of our former doubting specialists.

We divided the city into seven districts

for the general and two for the Negro population. Prenatal clinics and well-baby conferences were already established in connection with four settlement houses and four churches, so district boundaries were drawn with reference to these locations. Eventually we hoped to develop "health centers" in various cooperating agencies, each of which could serve as district headquarters or substation for the nurse assigned to that area. Realizing the many advantages of health centers in connection with settlements, we have not hesitated to change boundary lines and clinic locations as new settlement houses have come into existence. The settlements have desired this cooperative arrangement with an eagerness matching our own. As a matter of fact, the establishment of three out of four new settlements was contingent upon agreement that clinic and group teaching service would be provided by the Health Department. At the present time, we have 11 health centers, eight of them in settlements.

No phase of our progress is as truly representative of staff participation as our system of records designed to implement family health service. In some of our first staff conferences, we discussed the value of health service on the family basis. Objections were voiced in the argument, "With our terribly high infant death rate, how can we think about thorough service for a few families?" This argument soon gave way to the reluctant admission that, "The mass approach hasn't allowed our teaching to take root, so we might as well try the family approach." The staff realized there could be no movement in the direction of providing family health service until an adequate record system was installed. We studied sample record forms from various parts of the country. The final set contained much that is original plus borrowings from many sources.

PUBLIC HEALTH NURSING

By the end of the first year we had completed their installation; we had compiled a record manual; we had demonstrated convincingly that an efficient record system is fundamental to efficient organization. We have always had staff pride in "good" record work.

In the second year we compiled an operating manual. It was, and still is, a loose-leaf affair which facilitates revision. Gradually we had obtained standing orders covering clinic services and procedures in special types of service such as diarrhea control. We had worked toward fixed responsibilities and job descriptions, particularly for the office personnel. One by one these were added to the operating manual. The staff quickly recognized its organizational value; they were equally quick to realize that its value was in direct ratio to its current accuracy. As yet, however, we have not reached that degree of efficiency represented by an always up-to-the-minute manual of policies and procedures.

OUR STATISTICAL SERVICE

To supplement the limited data furnished by the vital statistics service of the Health Department the nursing division developed a statistical service. For this work the WPA supplied us with a capable clerk whom we trained step by step in the kind of statistics we needed. By the end of the first year we had monthly and annual graphs showing how our services were operating, charts, spot maps, tables of specific death rates, and a workable morbidity file.

Through many kinds of measurements we have seen our weaknesses and earnestly sought to correct them. We have gone about gathering facts, equipping ourselves with the unanswerable arguments needed for effective community education. We have not been the only users of these factual weapons. Our graphs and spot

maps have also seen frequent use by workers in other agencies.

WORKING WITH OTHERS

Close working relations with other agencies have made possible the development of many projects. As a matter of fact, practically all our activities have involved inter-agency cooperation, and form a veritable repertoire of adventure stories. There is the one about our participation in a summer camp for underprivileged children; the one about how we provided for one year an undergraduate affiliation in public health nursing, and how we secured quarters for a student center at one of the settlements; the one about how we have educated midwives in self-government by working closely with *Las Damas Profesionistas*, the "professional" organization of midwives. There is the story of a diarrhea control program, launched in 1941, planned and executed jointly by the Federation of Settlements and the Nursing Division, followed by a spectacular drop in the infant death rate; the long complicated story of how we secured the cooperation of seven agencies in making an extensive socio-economic survey in connection with a mass tuberculosis survey conducted by the U. S. Public Health Service; and the rather unique story of how some of the staff nurses, as they have followed one another in a certain district, have learned the art of interviewing and the art of family service to a remarkable degree because the director of the settlement, a particularly well-qualified social worker, agreed to a teacher-student relationship with the district nurse.

Through these ventures (we call them *adventures*) we have learned the everlasting truth of interdependence. For us, there is immeasurable satisfaction in hearing leaders in the field of social welfare comment on the activities of social work-

BUILDING AN ORGANIZATION

ers and public health nurses being "*interwoven* in an effective pattern of community service" because of an "exceptionally harmonious interlocking of ideas." We recall a time when our clinics were merely housed by other agencies. Today, each district health center service is an integral part of the total welfare program. Instances multiply where problems have been solved, with definite evidence of benefits to the family and to the community as a whole, through the joint thinking, planning and action of case worker and district nurse.

FLEXIBILITY, AN ASSET

These many cooperative undertakings have afforded us opportunities for rich and varied experience, and opportunities for extending our service as well. We have deliberately cultivated the quality of flexibility, a fortunate preparation for the changes, stresses and strains war has brought. Adjustments in our service to meet present conditions along the usual lines experienced by nursing agencies have been relatively easy.

HOPE FOR THE FUTURE

The community awakening process has gained momentum during the past three

years. In 1940, at the instigation of a few civic leaders, the American Public Welfare Association made a survey, the report of which shocked a few citizens, irritated a few others, and left that many less in the usual state of apathy. That same year, a community chest was organized. In 1941, a second family welfare agency was established; and five federal housing projects were completed. In 1942, with federal assistance and the cooperation of many agencies, the venereal disease control program was greatly extended and combined with a notably effective program of prostitution control. But the most important events, in our opinion, occurred last year when a graduate school of social service was established at one of our local colleges, and a school of public health nursing at another. These two schools not only provide a coordinating, stimulating and yet objective type of leadership; they also give us and our co-workers in other agencies the opportunity better to prepare ourselves for continued participation in community health education.

We know the long sleeping Demos is stirring. With that knowledge we take fresh hope and redouble our efforts to hasten the day of complete awakening.

THE AMERICAN JOURNAL OF NURSING FOR NOVEMBER

Blast Injury, Sam L. Clark, M.D.

Criteria of Essentiality for Nurses.

When Patients Go Home, Elizabeth S. Atkins, R.N.

Fraudulent Fever, Virginia Hale, M.D. and Olga Evseichick, N.N.C.

The Needs of the Army Nurse Corps, Florence A. Blanchfield, A.U.S.

A Junior League Nursery School.

Extending Housing Facilities.

Malaria, E. R. Coffey, M.D.

Good Nutrition Under Rationing, Margery Vaughn.

Mental Hospitals in Wartime, Dorothy Deming, R.N.

A Premature Baby, Bessie R. Hogg, R.N.

Alumnae Provides Staff Replacement, Katherine F. McCabe, R.N.

We Traveled by Transport, Catherine Shaw (N.C.), U.S.N.

A Program of Child Study, Mary Jane Steiner, R.N.

Affiliation Contracts, H. Lenore Bradley, R.N.

Psychiatric Affiliation, W. Earl Biddle, M.D.

Loud cheers and clapping of hands for the volunteers who daily give their heads and hands to the service of public health nursing. Without them, public health nursing could never have come so quickly through its early stages to the high point of efficient public service it stands for today. With them, public health nursing can be further strengthened until it extends to every family and community across the nation which needs the help it can give. In grateful appreciation NOPHN introduces the first of its Volunteers-of-the-Month. Mrs. William Bell Cook is third vice-president of the Seattle Visiting Nurse Service. Of her, Ruth E. Burcham, director of the Seattle VNA, writes: "She spends endless time working on publicity. She has never been a paid worker. Mrs. Cook has a very alert mind, and you no doubt have learned of her sense of humor. She writes quite frequently for 'American Home,' for several sports magazines, and has many articles in our local newspapers. Her photography has won local and state recognition. All this, of course, is extra-curricular. She has two sons, 13 and 15 years old, and a husband, a busy physician in the city—and they require some of her time. We are extremely fortunate in having her on the Board and in being able to profit by her efforts in publicity. She really is the 'answer to a maiden's prayer' as far as I am concerned." N.O.P.H.N. too, profits with a group of Mrs. Cook's fine public health nursing pictures in its loan file. To the magazine's request for a picture of herself to go with her story, Mrs. Cook's reply was characteristic: "About a picture—you've heard about shoemaker's children and shoes. Anyway, you ask me 15 years and 15 pounds too late!"

I Like My Job!

By BEATRICE COOK

EVER SINCE I toddled toward my first dose of Castoria, I've been interested in medicine. That dates me doesn't it? Forty years ago, nature was knocked out in the lack-of-vitamins round and never given a chance for a comeback. Dietetically speaking, children "just growed," like Topsy.

My grandmother smilingly said it was such a comfort to raise children before there were germs and automobiles. But I take exception to this. I'll willingly take my chances with traffic hazards and known bacteria rather than cringe under the black pall of despair which epidemics caused in early days. In my great-great-grandfather's book of memoirs is a heart-breaking letter to his brother in which he tries to justify and become reconciled to the death of his three children in three days from scarlet fever. As a minister

he tried to believe it was God's will but as a father he couldn't adjust his reasoning to the blow. Wildfire epidemics brought tragedy to countless families. Were they "the good old days?"

It may have been the fear and mute dread of disaster more than hard work which relegated mothers of that generation to the inactivity of the fireplace rocking chair at the age of 35. Worrying over the unknown and unforeseeable is harder than facing reality. In two or three generations, doctors, scientists and public health workers have revolutionized a mother's outlook and her whole life. They have put health on the assembly line! Today's anti-toxins and preventive medicine do more than cosmetics and the fashion experts to help the mother who joyfully announces to the world at large, "Life begins at forty."

I LIKE MY JOB!

To be connected with the progress of medicine, even in the most humble way, is satisfying. Those of us who work for and with the Public Health Nurse know she is entitled to a roped-off section in Heaven. Such unstinted devotion to the welfare of others should make headlines even in *The Paradise News*. It might read, "Nurse, just arrived, admitted for her optimism after 40 years of community nursing."

Now, near that choice section in the Golden Hereafter is a fairly good but less desirable space (with a more limited view of the Milky Way and secondhand harps) reserved for doctors' wives. They deserve it, and my only chance of heaven lies in this collective grouping. After 18 years of being married to a doctor, I often think of Mrs. Job, of biblical fame. Her husband crashed history with his boils. That was dandy for him but did you ever think what she put up with?

I've been a board member of the Seattle Visiting Nurse Service for years—and I like my job! Of course, anyone who does publicity for a thriving organization has her aspirin moments but they are generally followed by that most blissful of sensations—something accomplished. Spreading information by means of newspapers, magazines and radio about an agency tailor-made to fit public needs is tough, but interesting. There is nothing more gratifying than helping others to help themselves. I'm not giving my time; I'm investing it. Even though my efforts are a tiny part of its progress, I clip the coupons and check the dividends when figures show that our service is growing by leaps and bounds. After a full-page spread of pictures in a recent Sunday newspaper, the office had more new calls than ever before in one day, bringing to the agency many new patients who could appropriately be

served. Doubtless, there were many other factors but behind pulled shades and locked doors, I did some quiet gloating.

There! Back to normal and my altruistic mood has passed. Let me assure you, there's a lot of grief and many a pain and a slip t'wixt an idea for publicity and the final title on the contents page. And speaking of editors, does gastric ulcer cause the perennial grouch or vice versa? Perhaps printer's ink flows in their veins and makes them black-hearted. Or, because they are often an anemic and desk-ridden lot, maybe they are allergic to the phrase "Public Health." But, with patience and effort, they can be won over.

I've found the best way to bring a shadow of warmth into an editor's jaundiced eye is to show him good glossy pictures—and then mildly suggest there might be a story with them. It was this discovery which changed my photography from the baby-in-the-bath to the nurse-in-the-war-plant type of picture. (My two teen-aged sons are greatly relieved. Their budding modesty has impelled them to paste small leaves, after the manner of Greek statuary, over parts of my too-candid infant pictures.) Recently when I found a drowned mouse in a solution in my basement dark room, I wished that first picture I took when I was only six hadn't turned out well. Beginning with that, I've been increasingly encouraged and when I came home with a few blue ribbons and prizes, the family tried to be sweet but they knew that, with my whipped-up enthusiasm, they were in for a bad stretch. For fun I browse around such fascinating fields as composition and trick lighting and I know ways of photographing fish so that sports editors mumble, "It ain't possible." But I shall never reach any heights—the Home

(Continued on page 646)

Infantile Paralysis Epidemics

(Continued from page 605)

prepared to give and teach the necessary nursing care to families. Widespread use of the Kenny method has brought added responsibilities and introduced new problems in agency services and training programs. Nurses whose information is based on study and reading of professional medical and nursing journals can help to clarify popular misconceptions which have arisen due to the publicity accorded the treatment.

Public health nurses want to know what type of training is necessary to qualify them to give the treatment, and agencies are asking for information concerning the number of nurses required and the resources for training.

Agencies planning to send members of their staff for instruction in the application of the hot packs or muscle re-education should consult their medical advisory committees to make certain that medical support is available to direct the treatment.

Courses in nursing and muscle re-education are given in several centers.* The nursing course provides instruction and practice in the application of the Kenny hot packs and ranges from one to two weeks in length. Communities are advised not to send nurses for this course unless a physician and physical therapy technician are available to assume responsibility for medical and treatment services.

The muscle re-education course, which also includes the nursing aspects, is nine weeks in length and is open only to qualified physical therapy technicians. A considerable number of public health nurses who are qualified in physical therapy have taken this course.

A six months' course in the Kenny method of nursing and muscle re-education has been offered in one university for nurses who have not had preparation in physical therapy. This course was doubtless instituted as a measure to meet emergency needs in epidemics of poliomyelitis in communities where no qualified physical therapy technicians are available. Since this course prepares the nurse to give physical therapy only for patients with infantile paralysis she is not qualified to give treatment for patients with other orthopedic conditions. Her services are therefore limited to epidemic seasons. The nurse would have competence and professional status in the entire field of physical therapy and would thus be more valuable to the community if she took an approved course in physical therapy (minimum length of course nine months) which incorporates the Kenny method of muscle re-education.

So much attention has been focused on specific techniques of this method of treatment that there is real danger these may become a ritual and that the total health and social needs of the patient may be overlooked.

Other problems which concern public health nursing agencies are: Should all nurses on the staff be prepared to give the Kenny hot packs? How many nurses should be sent to training centers for instruction? How much instruction can be given in the staff education program of the agency? Is the muscle re-education in the home possible or practical? Under what conditions should it be given?

Information which will help to answer some of these questions is being collected from public health nursing agencies in epidemic areas and will appear in an early issue of the magazine.

J. L. S.

*PUBLIC HEALTH NURSING, December 1942, p. 708.

Exhibits for Health Education

By MARION McKINNEY

THE PUBLIC health nurse of today is expected to carry on a more comprehensive program of education and interpretation of her work in the community than ever before. In such a program, various types of visual presentation are valuable aids.

The technique of visualization of facts and ideas may be applied widely in the field of public health and will enliven and clarify many situations in which the public health nurse is called upon to play the role of educator.

Then, too, for many of the people with whom the public health nurse works, the visual language is a much more efficient medium of communication than the spoken or printed word. It presents facts clearly, briefly, and simply so that they are readily understood.

Some concrete examples of the use of visual material by public health nurses may help to show its value. During the annual drive for funds, the director of a public health nursing organization in a small city wanted to bring the work of her organization to the attention of the public. For the window of the nursing center, on a main street, the exhibit shown in Figure 1 was prepared by a volunteer exhibit committee. Six smaller replicas of this exhibit were made and set up in the entrance halls of the schools where sugar rationing books were being distributed during the same week. The exhibit included charts showing the location of the nursing center, types of service, and charges for each. It aroused con-



Figure 1

siderable interest in the community and prepared the way for a later appeal for funds.

By another director of a local public health nursing organization, visualization of the statistics of the organization was employed to liven up the annual meeting of the board which she felt had been formerly somewhat dull and perfunctory. She, herself, prepared a series of pictorial charts showing in an attractive way, the number of nursing visits, the racial and age grouping of patients, the various types of visits, and other data. Using these charts as the basis of her discussion, she was able to arouse lively interest on the part of the board and to give them a clearer and more lasting impression of the year's work.

In the educational work of the child hygiene service, simple demonstrations and exhibits are extremely useful in in-

teresting mothers in ideas and in teaching facts about child health. In one conference, the staff nurse found a simple exhibit helpful in arousing interest in sunbaths. Two small dioramas were made in each of which a scene was set. One represented the summer sunbath with a baby lying on a blanket on the green grass. With the blue sky behind him, the sun streaming down on him, and just the suggestion of a flowering tree at the side, he made an appealing picture. In the other, the interior of a room was shown with a crib arranged near the open window for a winter sunbath. Printed directions for sun bathing were given out with the exhibit.

In connection with teaching communicable disease control to home nursing classes, another staff nurse used an exhibit of a miniature child's room. By carrying out in it the various steps necessary to prepare it for the isolation of a case of scarlet fever, she was able to make this process much clearer and more realistic for her class.

At the present time, when the importance of nutrition to health is being stressed, a series of exhibits in connection with a nutrition consultation service in a health center has proved a most effective way of bringing home essential facts about food to the people attending the clinics there.

To prepare such simple visual material as has been described for use in health teaching, it is not necessary to be an expert in display technique. Any one who is original and successful in dramatizing ideas, clever in working with her hands, and willing to spend thought and effort in exhibit-making can turn out effective and attractive material.

BASIC RULES IN EXHIBIT MAKING

For the public health nurse who wants

to try her hand at exhibit making, the observance of a few rules will help in achieving good results.

1. Work out clearly the idea which you are to use. Decide on the group which you want to reach and also what you want the effect of the exhibit to be on this group.

2. Express the idea in a clear and arresting caption which can be easily understood.

3. Try to visualize the idea in a way that will be vital to the audience.

4. Work out a good design and attractive color scheme. The main idea of the exhibit is set forth at the center of interest which is made to stand out as the most important spot both in design and in the color scheme. The design of the exhibit should lead the eye from the center of interest to subordinate ideas which can be brought into the plan in their proper relationship to the main idea. However, do not have too many of these so that the exhibit seems crowded. For the background, the color should be neutral so as not to distract the eye from the main features of the exhibit.

If inexperienced as to the principles of design and color, look up a simple discussion of these, and of their practical application. Experimenting with practice sketches and small scale models will help you to plan an effective exhibit.

5. Adapt the whole method of presentation to the group to be reached. Words, objects, pictures, or symbols employed should be familiar to and have meaning for the members of the group.

The preparation of a collection of visual material adapted to the needs of the public health nurse need not entail a large expenditure of money. It does require ingenuity in the use of materials and time for and perseverance in looking them up. Of course, some money is needed for the

purchase of materials—more than that needed a few years ago as most of them have gone up in price. Some are not available at present because of the war.

WITH HAMMER, NAILS, AND PAINTBRUSH

If a nurse does not have the ability nor the facilities for doing the carpentry work needed for basic construction of exhibits, she may be able to get outside help with this. Suggested sources of such help are manual training classes in the schools or volunteers who make a hobby of wood-working. It is sometimes possible to get simple construction work done by an "odd-job" carpenter at a moderate rate.

On the other hand, if a nurse wants to do her own construction, she can get a great deal of help from books on wood-working and home carpentry. Screens and panels are not difficult to construct from beaver board, masonite, or plywood. Panels of beaver board must have good supports put on with plenty of small flat-headed nails as it is apt to warp. "Masonite Studio Board" is strong, does not warp, and comes in thicknesses of 1/4 and 1/8 inches. Plywood is a very useful exhibit material which comes in thicknesses from 1/16 to 3/4 inches and in large sheets 3 or 4 feet wide, and 8 feet long. Panels can easily be made from it, but it cannot be obtained at present except in occasional odd-size pieces without a priority rating. For dioramas, frameworks, and standards, white pine and whitewood (poplar) are the most satisfactory materials. All of these materials can be obtained from a lumber sales company.

For some exhibits, the background may be constructed of heavy cardboard which now comes in many colors and imitates other surfaces as wood or leather. Corrugated cardboard and seamless paper, a strong wide paper with a soft mat finish

which comes in a great variety of colors, are also good for backgrounds. These materials may be obtained in heights up to 8 feet, are easy to handle, and lend themselves to many treatments. They can be obtained at stores selling display materials. Would-be exhibit makers can often get suggestions for their use from these stores, from their catalogs, or from looking at good window displays.

If it is possible to get discarded backgrounds from ready-made store window displays, these can be recovered or re-finished—sometimes very successfully.

After the construction of the basic parts of an exhibit, the next consideration is the finishing and decoration.

Several coats of "flat" oil paint or one coat of a "water" paint will give to a surface a dull finish and these paints can be obtained in a large range of colors. For a hard, glossy finish, enamel may be used.

If it is desirable to keep a natural wood finish, several coats of white shellac with sandpapering between the coats may be applied. Or to bring out the grain of wood, brush on a mixture of half-and-half boiled linseed oil and stain. After allowing this to dry, two or three days, rub on a good floor wax with a cloth until the desired luster is produced. These materials may be obtained at a paint shop or in small quantities at ten-cent stores.

Sometimes it works out better to cover the background and basic parts of an exhibit with paper or fabric. Seamless display paper, already mentioned, is good for covering screens, panels or boxes. Oil-cloth, sanitas, display material imitating leather, and cotton duvetyn or other fabrics are useful materials. For special purposes, fabrics imitating grass and papers imitating sand, brick or stone walls may be obtained at stores selling display supplies.

PUBLIC HEALTH NURSING



Figure 2

For the application of color in the decorations on any part of an exhibit, various media are available. The water paints mentioned or tempera poster paints may be used for the decoration of large areas. For smaller touches of color, regular artist's oil paint thinned with turpentine to the desired consistency is a practical medium as it can be bought in many colors in small tubes for a low price. Plywood "cut-outs," decorated with color and glued or screwed to the background of an exhibit are effective for giving a suggestion of their dimensions.

MAKING FIGURES

It is sometimes effective to use decorations made of paper and for this purpose, the construction and poster papers are good and easily obtained.

In arranging miniature models of indoor or outdoor scenes, small objects are necessary. These may be found in five- and ten-cent stores, toy shops, or shops where favors are sold. One precaution

to be observed in using these, which is often disregarded, is to have everything in scale in a scene.

Sometimes volunteer helpers can be found who will make clay models to order for an exhibit. Or interesting dolls or puppets, especially attractive to child audiences, can be made from muslin. If well done, paper figures are very effective.

Figure 2 shows an exhibit using puppets to teach children about healthful clothing for winter wear. These were made by a group of volunteers, one of them an art student, who by her characterizations in the faces of the puppets gave the exhibit a great deal of humorous appeal. Stick and wire figures, if cleverly made, are also possibilities for small exhibits.

Photographs and colored illustrations from magazines or books lend themselves to many uses in exhibit-making. Faces and figures from enlarged photographs may be mounted on heavy cardboard or wood and then cut out.

HEALTH EDUCATION EXHIBITS

One group of volunteers made for an exhibit large, conventionalized figures of children cut from beaverboard with standards of wood attached to the back. The faces were blank, but the hair and clothing were painted on, and the whole effect was quite pleasing.

LETTERING THE TEXT

Lettering is a most important part of exhibit-making. Many nurses become discouraged at the prospect of the lettering for an exhibit. If you cannot letter or get a volunteer to do freehand lettering, there are other ways to solve this problem. There are many ready-cut letters on the market in different materials, sizes, and colors. It is possible to trace letters from lettering books or use lettering stencils which are not difficult to operate. Letters may be traced and cut out of wall board or wood by means of a jig saw. A visit to a local store selling display materials may offer many suggestions about available letters and their use. For those not within reach of such a store, the following list may be helpful:

Wrico lettering guides and pens

Eugene Dietzgen Company, 103 Park Avenue, N.Y.C.

Cut-out pasteboard letters

Carlo, Inc., 220 Fifth Avenue, N.Y.C.

Dennison Mfg. Company, 411 Fifth Avenue, N.Y.C.

Eagle Supply Company, 327 West 42nd Street, N.Y.C.

Cut-out wood letters

Manhattan Wood Letter Company, 151 West 18th Street, N.Y.C.

Plastic letters

W. L. Stensgaard and Associates, Inc., 30 Rockefeller Plaza, N.Y.C.

Gum

Mitten Display Letter Company, Redlands, California

Gummed paper letters

Tablet and Ticket Company, 115 East 23rd St., N.Y.C.

Felt and metal letters



Figure 3

Adler-Jones Company, 521 South Wabash Avenue, Chicago, Ill.

DESCRIPTION OF EXHIBITS ILLUSTRATED

Figure 1.

This is a window display which was not difficult to construct. The background was made of three upright supports ($\frac{3}{4} \times \frac{1}{2}$ -inch pieces of wood) nailed to a base of a one-inch board (24 inches long by 8 inches wide). To these upright pieces was tacked a piece of heavy, white cardboard on which a colonial doorway was painted in black and gray. The edge of the door was cut so it could stand part way open. To the top of the standards was fastened a band of blue seamless paper with the caption painted on it in white. The base was covered with red brick paper to represent a terrace. To another piece of one-inch board (12 inches square) also covered with brick paper and representing a walk, was wired a doll dressed in the official uniform of the nursing agency. Another doll, representing a child, was placed in the doorway. The shrubbery was cut from $\frac{1}{4}$ -inch plywood and painted green. The posters at the side show the area covered by the nursing agency and the rates for the various types of service.

Figure 2.

This exhibit was included because it uses puppets very effectively. The background of the exhibit was made from craft paper painted

PUBLIC HEALTH NURSING

in a simple design with poster paint. At the left is a scene suggesting a rainy day with the appropriate clothing. On the right is a snow scene with the children in proper garb for winter weather. The placards have amusing jingles giving the necessary advice about clothing. This was planned for the window of a health center next door to an elementary school.

Figure 3.

This shows a simple exhibit incorporating several features of construction which might be used by nurse exhibitors.

It is a table exhibit which can be taken apart and packed flat for transportation. The panel was made from $\frac{3}{4}$ -inch plywood painted gray and the supports were sawed from $1\frac{1}{4}$ -inch pine board and painted the same color.

The housewife, who might readily be identified with any of the clinic mothers, formed the center of interest in her red and white checked

dress and red apron. She was made of muslin, stuffed with cotton with her face painted and her hair made of wool.

The letters, of black cardboard, were bought ready-cut and pasted on with rubber cement.

The dollar bill in green, the dimes in silver, and the attractively colored food models add color interest.

SUGGESTED READING

Graves, Maitland E. *The Art of Color and Design*. McGraw-Hill Book Company, Inc., New York, 1941.

Hamilton, Edwin T. *Home Carpentry*. Dodd, Mead and Company, Inc., New York, 1940.

Hjorth, Herman. *Basic Woodworking Processes*. Bruce Publishing Company, New York, revised edition 1935.

National Publicity Council. *Exhibits: How to Plan and Make Them*. The Council, New York, 1943.

Degrees and Certificates in Public Health Nursing Programs of Study

IN SEPTEMBER, 1942, there were 31 programs of study in public health nursing approved by the Committee on Accreditation of the National Organization for Public Health Nursing, with some changes in this number during the ensuing year. Each year universities and colleges which offer these programs are asked for information about various aspects of their work. A tabulation of replies from the 29 on the approved list as of July 1, 1943, about the number of degrees and certificates awarded in the year ended July 1, 1943, shows that 388 baccalaureate degrees were awarded, and 43 master's. Certificates are not granted

by some of the schools. Some of these, however, were able to give the number of students who had completed the program of study in public health nursing, or who had completed the requirements for a major in public health nursing. There were 443 students who received certificates, or who had completed the public health nursing courses. We believe that each student is counted only once in the following table. A handbook giving about forty words of description for each program of study is available at the NOPHN. More detailed information can best be secured by writing directly to the college or university.

**DEGREES AND CERTIFICATES IN PUBLIC HEALTH NURSING IN APPROVED PROGRAMS
OF STUDY, 1942-43**

Name of college or university	Number of students ¹ receiving degree or certificate		
	Baccalaureate degrees	Master's degrees	Certificates
Total, all programs of study	388	43	443
California, Berkeley, University of California	20	—	39 ²
California, Los Angeles, University of California	22	—	29
Colorado, Boulder, University of Colorado	1	—	6
District of Columbia, Washington, Catholic University of America	6	—	6 ³
Illinois, Chicago, University of Chicago	2	—	— ³
Illinois, Chicago, Loyola University	6	—	11
Indiana, Bloomington, Indiana University	9	—	— ³
Massachusetts, Boston, Simmons College	2	—	46
Michigan, Ann Arbor, University of Michigan	10	2	15
Michigan, Detroit, Wayne University	6	—	10
Minnesota, Minneapolis, University of Minnesota	80	6	— ⁴
Missouri, St. Louis, St. Louis University	9	—	1 ⁵
New Jersey, Newark, Seton Hall College	1	—	2
New York, Brooklyn, St. John's University	2	—	—
New York, Buffalo, University of Buffalo	6	—	5
New York, New York, Columbia University, Teachers College	42	11	— ^{3, 6}
New York, New York, New York University	46	17	—
New York, Syracuse, Syracuse University	7	—	30
North Carolina, Chapel Hill, University of North Carolina	1	—	7
Ohio, Cleveland, Western Reserve University, Frances Payne Bolton School of Nursing	14	2	42
Oregon, Portland, University of Oregon	43	—	31
Pennsylvania, Philadelphia, University of Pennsylvania	5	2	42
Pennsylvania, Pittsburgh, Duquesne University	3	—	5
Pennsylvania, Pittsburgh, University of Pittsburgh	13	—	—
Tennessee, Nashville, George Peabody College for Teachers	21	2	40
Tennessee, Nashville, Vanderbilt University	1	—	20 ³
Virginia, Richmond, Medical College of Virginia	—	—	21
Washington, Seattle, University of Washington	8	1	24
Wisconsin, Milwaukee, Marquette University	2	—	11

¹ Each student is counted only once. Some received both degrees and certificates during year. These are included in the degree columns.

² Certificate following B.S. degree.

³ Does not grant certificate. If number is entered, the number indicates students who have completed the program of study in public health nursing.

⁴ Certificates were granted to 15 students with B.S. degrees before entering course in public health nursing. Students earning a degree at Minnesota are automatically given a certificate.

⁵ Certificate issued to holder of a degree in nursing education. St. Louis does not usually grant certificates.

⁶ It is estimated that 40 additional students may have completed work of the major in 1942-43.

A COURSE of three lectures on rheumatic fever will be given for professional workers under the auspices of the New York Heart Association (The Heart Division of the New York Tuberculosis and Health Association) on Tuesdays, November 23, 30, and December 7 at 4:00 p.m., at the Einhorn Auditorium, Lenox Hill Hospital, 109 East 76th Street, New York, N. Y. Lectures will cover the public health aspects of the disease; the nature of the disease; the management and the community facilities. Admission by ticket only, supplied free on request to the New York Heart Association, 386 Fourth Avenue, New York 16, New York, Caledonia 5-2240.

Functions of Nurses In Industry*

INDUSTRIAL HYGIENE is rapidly taking its place in the forefront of the total community health program. No other aspect of the health program has an equal chance to reach directly and quickly so large a group of the population. This is a group whose health and efficiency are of first economic importance—that of adult wage earners. More and more health service in industry is broadening to include general health supervision of workers as well as prevention and treatment of industrial disability.

Events have combined to place far-reaching responsibilities on the industrial nurse. The war has meant extension of service to thousands of new plants and because of lack of medical personnel, the delegation of new duties to the nurse by the physician. In many plants the nurse is the one person in the health service who is always available when accidents or similar emergencies occur.

The daily routine of an industrial nurse is shaped by the needs of her plant. The degree of interest on the part of management in health and welfare, the budget available to the health service, provisions for medical service, hazards of the industry, community resources, and the nurse's initiative, professional training and insight—all are factors which determine specific duties. Certain generally recognized principles are the basis for program planning:

1. Nursing care should be given under the direction of a licensed physician.

2. The physician employed by the plant should provide written standing orders for the guidance of nursing personnel.

3. Nursing care should be given by or under the supervision of a graduate nurse, registered in the state in which she is working.

4. Nursing supervision or counsel of nursing personnel in the sense of professional guidance and development should also be available. This should be given by a nurse supervisor employed by the industry if the health service is large enough to make such a plan practical. For the nurse working alone, valuable assistance may be procured from state and local departments of health, state industrial nurse consultants, other local community health agencies, or professional nursing organizations. Some insurance companies provide nursing consultation for nurses serving insured persons.

5. As far as practicable, the service given by nurses should be limited to professional duties. This is in keeping with the national endeavor to extend available nursing service to meet the increased demands of wartime.

6. The industrial health service should be responsible to an executive of the organization. When the nurse is the only full-time worker in the health service she should have free access to the executive of the industry who is responsible for its operation.

*Prepared by the Executive Committee of the Industrial Nursing Section of the National Organization for Public Health Nursing.

NURSES IN INDUSTRY

Duties of industrial nurses are:*

1. Maintenance of dispensary
 - a. Requisition and arrangement of adequate supplies
 - b. Maintenance of a scrupulously clean dispensary
 - c. Representation of plant health service in interdepartmental planning and discussion in absence of plant physician
2. Nursing care and treatment of occupational injuries and illnesses (as defined in written standing orders signed by responsible medical authority)
 - a. Emergency care of all injuries
 - b. Redressings as indicated
 - c. Assistance to physician in care of injuries
 - d. Special service to the injured worker, such as calling ambulance or notifying family (When an injured or sick worker is transported in his own car or is taken by some other person, it is the obligation of the nurse to see that he is properly escorted)
3. Emergency care of nonoccupational disabilities and referral for further care when necessary
4. Assistance with medical examination of workers
 - a. Interviews with workers previous to the examination in order to explain procedures and their significance
 - b. Making routine tests and measurements such as height, weight, vision and hearing acuity, making dental inspections, taking blood pressure, pulse, temperature and respiration, obtaining specimens for serological examinations and other laboratory tests
 - c. Interpretation to the worker of plant policies regarding his health and welfare and his responsibility for cooperation
 - d. Attendance at physical examination of women workers
 - e. Periodic inspections for symptoms and indications of occupational disease
 - f. Inspections and interviews with workers in connection with return-to-work permits
 - g. Special duties requiring technical training: laboratory work, X-ray, physiotherapy, electrocardiograms, basal metabolic tests
5. Participation in a program of general health supervision
 - a. Follow-up for correction of defects revealed by medical examination
 - b. Planned supervision of workers with adverse chronic conditions
 - c. Planned rehabilitation of workers with physical handicaps
 - d. Counsel to individuals regarding specific health problems
 - e. Health instruction as part of training or induction course for new employees
 - f. Promotion of organized health activities in cooperation with community agencies, such as control of tuberculosis, venereal, respiratory, and other communicable diseases, and mental hygiene, nutrition, dental hygiene, and rehabilitation
 - g. Preparation of articles on health for publication in plant bulletin
 - h. Health talks before employee groups, including labor union meetings
6. Participation in safety education and accident prevention
 - a. Attendance at safety committee meetings
 - b. Promoting the use of visual education facilities such as movies, posters and selected printed materials
 - c. Instruction of classes in first aid
 - d. Distribution and care of protective equipment
 - e. Assistance in establishing procedures to be used in emergencies, such as fires or war disaster
7. Assistance with plant sanitation (primary responsibility to be assumed by the nurse only if no other department can give this service)
 - a. Active interest in all phases of plant environment that affect the health and morale of workers and suggestions to management for improvement
 - b. Supervision of matrons or direct supervision of rest rooms, wash and change rooms
 - c. Assistance in supervision of ventilation, lighting and housekeeping
8. Participation in welfare programs in the plant
 - a. Advice to workers regarding group sick benefits, hospitalization and life insurance plans; interpretation of such plans carried by employer
 - b. Counsel to workers regarding individual problems
 - c. Promotion of recreation program
 - d. Cooperation in planning facilities for food, with emphasis on provision of desirable menus

*Based on the Report of the Committee to Study Duties of Nurses in Industry of the Public Health Nursing Section of the American Public Health Association. PUBLIC HEALTH NURSING, July 1943.

PUBLIC HEALTH NURSING

9. Home nursing service

a. Visits to ill or injured workers to make plans for nursing and convalescent care and to meet special needs for rehabilitation

b. Giving nursing care when community resources are not available or, because of plant policies, cannot be utilized. (Home nursing care is occasionally provided by medical benefit association)

c. Instruction in principles of good health and prevention of injuries and illnesses

d. Assisting family with social problems

e. Cooperation with community health agencies in all matters relating to the health of the worker and his family

10. Nursing care in hospitals operated by the industry

11. Maintenance of adequate health records and reports, of which the following are essential:

- a. Daily record or log of the nurse's services
- b. Health record of each worker

This may be filed in an individual folder containing the report of pre-employment physical examination, record of clinical visits, and care and advice given

c. Workmen's compensation records and reports

d. Disability absentee records of both industrial and nonindustrial disability

e. Monthly and annual reports to management

Analysis of records as basis for:

a. Advising individual worker in matters relating to health

b. Reports and interpretation of plant medical service to management

c. Indication of hazards and problems of the particular industry

d. Evaluation of health service

e. Program planning, development and extension of health service

12. Cooperation with community health agencies

a. Integration of the health program of the plant with that of the community, including private physicians, community nursing services, safety committees and other health and welfare agencies

b. Cooperation should include participation in the community health program so that a complete health service to the individual is achieved

I Like My Job!

(Continued from page 635)

Economics taint is still in my blood. I have the work-a-day soul of a graduate dietitian—not an artist.

However, that does not bother me. Living and learning has taught me that it is wasted energy to be too serious about lots of things. If left alone, most issues work themselves out and the blessed law of compensation is on a 24-hour shift. But I'm in dead earnest and very serious about the health, happiness and welfare of my family—and because of my public health knowledge, in a broader sense my

family includes the whole community. Ultimately, we are only as safe and well as our neighbors. Seattle's problems are my personal concern. Leading the list of How To Be Unpopular With Your Friends are the smug and lonely isolationists who are playing the losing ostrich game.

So, I'm grateful for the privilege of being able to help push such a tremendous force for community good as public health nursing. I am glad to be living on the threshold of the postwar era in which we shall find it sound economically as well as spiritually to be "our brother's keeper."

Reviews and Book Notes

THE PRINCIPLES OF VENEREAL DISEASE CONTROL

U. S. Public Health Service, Supplement No. 17 to
Venereal Disease Information. 105 pp. U. S.
Government Printing Office, Washington 25,
D.C., 1942. 20 cents.

This publication contains a detailed discussion of the recommendations for a venereal disease control program, in state and local health departments, by the Advisory Committee to the United States Public Health Service. The committee is made up of experts in the treatment and control of the venereal diseases—and the authors are known nationally and internationally.

The pamphlet is especially addressed to health officers and physicians, but should also be available to all public health nurses, whether they are chiefly concerned with an official venereal disease program or not.

The authors have presented such topics as the following in a clear, concise and interesting manner: the organization and administration of the venereal disease program; statistics and special studies; epidemiologic reports; laboratory, treatment and diagnostic services; case holding and case finding; education of professional groups and the general public; the problems of the charlatan and the prostitute; prophylaxis; national defense and control measures; financing the program; and the relationships of the broad social hygiene program to that of health department activities.

The pamphlet contains also discussion of such diseases as chancroid, granuloma inguinales and lymphogranuloma venereum. An appendix includes useful ma-

terial on the recommended qualifications for health officers and nurses participating in the venereal disease program and the U. S. Public Health Service's nomenclature for syphilis; and a suggested reading list. The pamphlet should be required reading in public health nursing courses and on the reference shelves of every public health nursing agency.

GLADYS L. CRAIN, R.N.
Buffalo, N. Y.

SOCIAL WORK

By Helen Leland Witmer. 539 pp. Farrar and
Rinehart, Inc., New York City, 1942. \$3.

This book is a "record of an attempt to discover what social work really is." The fallacy of believing all activities of social workers to be social work is pointed out. In the same way, the confusion often existing regarding such terms as social welfare, public welfare, and social work is clarified.

Miss Witmer's book should prove helpful to supervisors in public health nursing in guidance of the staff in more effective use of the services of the social worker. Admittedly, there is frequently confusion in programs, such as in the crippled children's services, as to where public health nursing ends and medical social work takes over. Miss Witmer clarifies this point. She gives the prime function of social work as "to give assistance to individuals in regard to the difficulties they encounter in their use of an organized group's services or in their own performance as a member of an organized group." She further shows that "problems that individuals encounter in using their serv-

PUBLIC HEALTH NURSING

ices are resolved through individual counseling and other forms of assistance that social work gives . . . Social work is an institution that serves other institutions." A chord familiar to public health nurses is sounded when Miss Witmer gives as a working principle of social work the psychological truth that one person cannot make plans for another with any assurance that they will be carried out or that, if carried out, the results will be those desired.

In Parts I and II the author presents

with logic and clarity the nature and function as well as the evolution and present organization of social work. Part III is devoted to an explanation of how the social work function is discharged in various programs such as public assistance, family welfare, child welfare, and in medical, psychiatric and hospital clinics. This last part in particular might well be used as a reference in courses in public health nursing.

HAZEL HIGBEE
Cleveland, Ohio

RECENT PUBLICATIONS AND CURRENT PERIODICALS

WARTIME

SERVICES FOR CHILDREN OF WORKING MOTHERS IN WAR TIME. OCD publication 3625, U. S. Office of Civilian Defense. A manual for child care committees of local defense councils. June 1943.

WAR, BABIES AND THE FUTURE. William Fielding Ogburn. Public Affairs Committee, 30 Rockefeller Plaza, New York. 1943. 31 pp. 10 cents.

RECREATION—A Resource of War. Federal Security Agency, Division of Recreation, Social Security Building, Washington 25, D.C. 1943. 8 pp. Free.

This pamphlet has been prepared from a report titled "Spare Time—A War Asset for War Workers." It was prepared to help communities in war areas meet the off-the-job needs of war workers and their families.

ORGANIZING A COMMUNITY AND WAR CHEST FOR THE SMALLER COMMUNITY. Community Chests and Councils, 155 East 44 Street, New York, 1943. 16 pp. 25 cents.

GENERAL READING

THE WAR ON CANCER. Edwards Podolsky, M.D. Reinhold Publishing Company, New York, 1943. 179 pp. \$1.75.

SYNOPSIS OF DISEASES OF THE SKIN. Richard L. Sutton, M.D. and Richard L. Sutton, Jr., M.D. C. V. Mosby Company, St. Louis, 1942. 481 pp. \$5.50.

TEXTBOOK OF ANATOMY AND PHYSIOLOGY FOR NURSES. W. W. Tuttle, Ph.D., Carl C. Francis, M.D., G. Clinton Knowlton, Ph.D. C. V. Mosby Company, St. Louis, 1943. 586 pp. \$3.50.

THE METABOLIC COST OF MAINTAINING A STANDING POSITION. Harriet G. McCormick. Kings Crown Press, New York, 1942. 75 pp. \$1.25.

FILMS

FIVE FILMS made by Commercial Films, Inc., 1800 East 30 Street, Chicago.

To the Women—A new special sound slide film, addressed specifically to the woman worker and her health problems.

Take Care of Yourself—General health film addressed to all workers.

The Cold Bug—Film stressing the vast number of lay-offs due to colds.

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FIRST STEPS IN FIRST AID. Motion picture addressed by Louis F. Perry. Bureau of Mines Experimental Station, 4800 Forbes Street, Pittsburgh, Pennsylvania. No rental charge.

FILMS FOR AMERICA AT WAR. Pamphlet. Supplement No. 1 to Selected Educational Motion Pictures prepared for the Committee on Motion Pictures in Education. Available from the Council on Education, 744 Jackson Place, Washington, D. C. 97 pp. Free.

NOTES FROM THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

MISS DUNN TO ASSIST NATIONALS

At the joint request of the Association of Collegiate Schools of Nursing, NOPHN and NLNE, the U. S. Public Health Service has generously agreed to lend the services of Mary J. Dunn part-time to National Headquarters to implement the work of the Joint Committee on the Integration of the Social and Health Aspects in the Basic Curriculum.

The function of the Joint Committee was approved by the Boards of NLNE and NOPHN in January 1942 as a result of the recommendation of NOPHN's Education Committee in October 1941. Charlotte C. Skooglund, educational director, School of Nursing, Philadelphia General Hospital, is chairman. There have been six meetings and the principal accomplishment has been the formulation of the committee's objectives, now approved by the Curriculum Committee of the League and the NOPHN Education Committee. The objectives are primarily concerned with assisting schools of nursing to enrich their curricula by utilizing every opportunity for the integration of health and social aspects, advising public health nursing agencies as to ways they can assist schools most effectively in this, and working with state boards of nurse examiners in regard to their requirements for instruction and practice in "Nursing and Health Service in the Family."

The objectives, together with the problems growing out of the acceleration of the basic curriculum which have direct implications for public health nursing, will form the basis for Miss Dunn's work.

We are indeed most fortunate to have secured the services of such an outstanding public health nursing educator. Probably best known as director of the study of the content of the curriculum in public health nursing which was a joint project of the USPHS and NOPHN resulting in the publication, "The Public Health Nursing Curriculum Guide," Miss Dunn has been interested in problems of the whole field of nursing education, both basic and advanced. She was formerly associate professor of public health nursing at Vanderbilt University and for the past eight years has been a public health nursing consultant of the USPHS.

IN THE FIELD

U. S. CHILDREN'S BUREAU, Washington, D. C., October 4—Ruth Houlton attended a meeting of the nurse members of the Advisory Committee on Maternal and Child Health Services, together with the Nursing Unit of the C. B. . . . October 1 and 2—Jessie L. Stevenson and Carmelita Calderwood attended a meeting of C. B. regional nursing consultants to discuss crippled children's services. On the 4th, Miss Stevenson attended the meeting of the Advisory Committee; and on the 5th and 6th she represented the NOPHN at the first national conference on rheumatic fever programs called by the C. B. . . . 32ND NATIONAL SAFETY CONGRESS AND EXPOSITION, Chicago, Illinois, October 5-7—Heide Henriksen attended and represented the NOPHN at the Home Safety Sessions. She made

(Continued on page A13)

PUBLIC HEALTH NURSING

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(Continued on page A13)

NEWS

Highlights on Wartime Nursing

NURSES AND EMPLOYMENT STABILIZATION

A War Manpower Commission Field Instruction addressed to regional manpower directors on October 13 defines the status of physicians, nurses and other groups represented in Procurement and Assignment Service, under employment stabilization programs. All nurses are stated to be exempt from the controls established by employment stabilization programs. A large number of public health and industrial nurses in private employment are affected. In part, the instruction reads:

The great bulk of persons engaged in these professions are either self-employed or employed by government agencies—Federal, state or local. Hence, by far the greater number of these professional workers would be exempt from the controls established by employment stabilization programs even if no specific provisions for their exemption were made.

There are, however, 90,000 persons out of a total of 600,000 in these professions who are employed by such organizations as hospitals and industrial companies. In the absence of any special provision these professional persons would be subject to the same restrictions on hiring (*i.e.*, presentation of a statement of availability or referral by the local office of the United States Employment Service) as are applied to other workers covered by employment stabilization programs. In view of (a) the small number of persons involved (b) the technical nature of work done by most of the persons in these professions and (c) the existence of an effective mechanism of allocation through administrative procedures developed by the Procurement and Assignment Service, no person in these professions is subject to the controls set down in employment stabilization programs.

Your attention is directed particularly to the fact that nurses are not subject to the terms of employment stabilization programs . . . It should be emphasized that persons in these

professions are not exempt from the responsibility of every citizen to serve where he can make a maximum contribution to the war effort. The exemption of these persons related only to the manner in which their obligation to serve where they can be of maximum value is indicated to them.

Exclusion of persons in these professional groups from the controls established by employment stabilization programs has no effect whatever on the essentiality of the activities in which these persons are engaged (Group 32—Health and Welfare Services).

U. S. CADET NURSE CORPS

More than 1,000 schools of nursing have applied for acceptance in the U. S. Cadet Nurse Corps program, Lucile Petry, director, Division of Nurse Education, announced on October 12. The participating schools have estimated that a total of 84,710 students including those already in training and an estimated 41,156 new recruits, will be enrolled in the Corps during the year.

The first recruiting posters are being widely distributed throughout the country by the U. S. Public Health Service through the facilities of the Office of War Information. Boy scouts, field agents of the Department of Agriculture, and other distribution facilities are being drawn upon in order to place posters in every possible spot in the United States where potential nursing school candidates will see them. Miss Petry explains that October was chosen for the distribution month to initiate recruitment impetus for January and February classes. "If we waited until later we would encounter the holiday season and posters would not be on display until the middle of January which would be too late to be effective."

NEWS NOTES

- Hilda Torrop, director of the School of Practical Nursing of the Ballard School of the YWCA, Central Branch and president of the National Association of Practical Nurse Education, is spending half time with the Nursing Council studying the national situation as it relates to attendant nursing and assisting with the referral of suitable candidates to approved schools of practical nursing. State and local nursing councils are being asked to recruit attendant nurses as a parallel project with recruitment of other student nurses.

- Continuing their cooperation with the National Nursing Council and the Red Cross on nursing problems, the General Federation of Women's Clubs is inaugurating a nationwide program to promote enrollment of student nurses in the U. S. Cadet Nurse Corps and to provide scholarships for student nurses who are not members of the Corps. Women's clubs everywhere are being urged to cooperate with local nursing groups in this work. The General Federation is also promoting, at the Council's request, enrollment of suitable applicants in approved schools for practical nurses.

The Women of the Moose are continuing their nursing scholarship and recruitment work.

- At least 75 percent of all unmarried nurses now in the eligible group must volunteer for war service, according to late figures from the War Manpower Commission.

- Approval of professional nurses teaching Red Cross Home Nursing classes so that mothers and homekeepers may care for minor illnesses in their own homes, and if necessary, even give "intelligent assistance in time of local emergency" was voted by the National Nursing Council for War Service at a recent meeting in New York City.

- Fall institutes for directors of schools of nursing have been scheduled in 28 states by the Council's Educational Field Service of which Anna D. Wolf, Johns Hopkins, is chairman and Helen G. Schwartz, Cincinnati General Hospital, is director. Subjects they will cover include better organization and use of existing educational facilities, better student guidance and personnel policies, better faculty preparation.

From Far and Near

- Ellen L. Buell has been appointed professor of public health nursing at the Frances Payne Bolton School of Nursing, beginning October 1, 1943. Since 1930, Miss Buell has organized and directed the Department of Public Health Nursing at the College of Medicine, Syracuse University, which institution has granted her leave of absence for the academic year 1943-44. Ruth TeLinde, who has been associated with the Department of Public Health Nursing at Syracuse since 1936, has been appointed acting director during the absence of Miss Buell. Lilly Harman will serve as Miss TeLinde's assistant. Miss Harman comes to Syracuse

from the Bureau of Nursing, Baltimore City Department of Health.

- Donna Pearce, formerly public health nursing consultant for the Venereal Disease Division of the U. S. Public Health Service, has recently been assigned as public health nursing consultant to District VI, USPHS, which serves Puerto Rico and the Caribbean Islands. There are now 181 public health nurses serving in Puerto Rico. Miss Pearce succeeds Mrs. Florence Callahan who has been transferred to USPHS District V, which has headquarters in

(Continued on page A11)

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THE FIRST EDITION of the CANNED FOOD REFERENCE MANUAL was welcomed by the medical profession. It quickly established itself as a convenient, authoritative source of information on canned food and nutrition.

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A CHRISTMAS MESSAGE

from

SURGEON GENERAL THOMAS PARRAN
U. S. PUBLIC HEALTH SERVICE

PERHAPS NEVER before in the history of the world has there been such need for skill, intelligence, courage and unswerving devotion to duty. War is a harsh teacher and a cruel one, but it is teaching us to forget ourselves as individuals and to dedicate ourselves to service in the cause of freedom without regard to self.

As public health nurses you pledged yourselves to serve when you entered one of the great life-saving professions. War has accentuated the already great needs for your services. You have been called on to do a yeoman job. You have worked in war communities whose populations have swelled overnight but whose health services had not kept pace with population growth. Everywhere—in towns, cities, and rural communities—you have been asked to take on new and additional responsibilities that the health of our civilian army might be protected. You have worked long hours, under trying conditions, in all kinds of weather.

You, too, are soldiers in the cause of health. But yours has been that quieter heroism which performs its day-to-day tasks without fanfare of trumpets or roll of drums. In giving your skill, your trained minds and your hearts to the health protection of the Nation, you are playing an essential role in winning the war and in winning the peace for which we all long deeply.

Your rewards have not been material ones, but I believe you have found them soul-satisfying. The look of confidence on the face of the expectant young mother whom your calm reassurance has freed from fear of the ordeal to come, the grateful eyes of the bedridden ones whose pain you have eased, the confidence, the trust, and reliance placed in you by those whom you serve—these have been rewards which cannot be assessed in material terms.

President Roosevelt has said that the deeper purpose of democratic

PUBLIC HEALTH NURSING

government is to assist as many of its citizens as possible, especially those who need it most, to improve their conditions of life. The world looks to the health professions to heal the wounds of war and to raise the standard of health to new levels.

In the days of peace to come, there will be need for leadership in teaching and practicing the ways of healthful living. As public health nurses you have the chance to do more than pay lip service to an ideal way of life. It will be your privilege to make that ideal a living truth as you give yourselves to the task without regard to race, creed, or economic status.

Even in the depth of war, we must plan for the peace to come. Especially at this Yuletide season, we in America and our allies throughout the world work and fight to bring once more to nations everywhere—**PEACE ON EARTH, GOOD WILL TO MEN.**

Tuberculosis in Wartime

WAR SUPPLIES fertile soil for the spread of tuberculosis. Up to the present time we have not noted a rise of mortality in this country, although we have clear evidence that both the death rate and the incidence of infection have increased in European nations. The fact that hostilities have not touched our shores may account for most of our fortunate situation. However, many of the ill effects of war are threatening our people—vast industrial concentrations, overcrowded living conditions, speed-up of production with physical fatigue, lack of recreation, improper nutrition, the continuous nervous strain inevitable in the present world chaos.

Mass surveys through chest X-raying



of drafted men for the armed forces and a growing proportion of industrial workers, have revealed an unexpected number of infections—more than one-half of these in the minimal or early stage of the disease. Thus, while the mortality still shows a slight decline, the registered cases have increased. These are curable with immediate follow up and treatment.

This lays an added burden on the public health nursing profession already handicapped by loss of personnel. Even though shorthanded they must not relax one iota of their vigilance if we are to maintain the necessary standards of health education and protection to insure

(Continued on page 664)

Nursing in Foreign Relief and Rehabilitation

By MARGARET G. ARNSTEIN, R.N. AND THERESE KERZE, R.N.

THE RECENT favorable progress of the war and the consequent opening up of areas needing assistance has sharpened public interest in the activities of the Office of Foreign Relief and Rehabilitation Operations. As the name implies, this organization is responsible for relief and rehabilitation in war stricken countries. This office has recently been made a constituent part of the new Foreign Economic Administration, which coordinates all economic activities of the Government overseas. FEA commences operations as soon as the Army feels that a situation is stabilized enough to allow civilians to enter. It works closely with the Allied Military Government, learning what they have been doing in the field of relief and rehabilitation, then gradually taking over this work and enlarging its scope.

The nursing profession has been wondering for some months just where nursing would fit into this picture. No clear-cut answer can be given at this time because as yet a full medical unit has not been sent overseas, and therefore there is no actual experience in the field to describe. In the near future the United Nations Relief and Rehabilitation Administration* will be established and this

agency, operated by all the United Nations, will administer relief and rehabilitation in liberated countries. It is expected that the work of the Office of Foreign Relief and Rehabilitation Operations, or OFRRO^{1,2} as it is called, will be absorbed in this larger international organization and relief and rehabilitation in this manner made a responsibility of all the United Nations rather than of a few nations or just one, acting by itself. However, it seems worth while to describe briefly what has happened to date, particularly in reference to nursing.

FIRST of all one must keep clearly in mind that the medical unit is only a part of the whole and in terms of numbers of personnel, a very small part. Nursing in turn is only a small part of the medical unit. The first and most pressing job is the provision of supplies, food, clothing, goods of all kinds, including medical supplies. To distribute them, transportation is required and experts in transportation, merchandising, warehousing and financing are required.

The medical unit has been thinking of the problems likely to be encountered and the supplies which probably will be needed. Special committees have studied pre-war conditions and more recent reports which have filtered through from the occupied countries. Dr. James A. Crabtree, director of the Health Branch

*The agreement for the United Nations Relief and Rehabilitation Administration was signed by representatives of 44 governments on November 9, 1943.

of OFRRO, summed up the problems which are expected in his speech before the meeting of the American Hospital Association in Buffalo, on September 15:

If I were required to list the first three public health problems in the order of their urgency, I should not hesitate to place at the top of the list starvation. Epidemics, I think, might meet all other challenges for second place. Running a close third would be the special problem of maternity and infancy.

The provision of the necessary medical facilities and public health safeguards whereby these people can be returned and restored to their homes and families will constitute one of the major public health undertakings of relief and rehabilitation. Here one may anticipate the entire gamut of public health problems with some emphasis on orphaned children, expectant mothers, the venereal diseases, and general illness, but with the whole picture dominated by epidemic disease.

Beyond appraising the needs for supplies, then supplying the goods and giving general supervision to their distribution and use, it is not known how much assistance will be needed in each country. The present plan is to send a small medical unit as a part of each foreign relief mission and each unit, in the earlier phase, will have a chief medical officer, sanitary engineer, public health nurse, and five or six other professional persons with considerable administrative experience.

The medical units of relief missions, in general, will administer and direct medical and public health activities for the mission. They provide assistance to the national personnel in reorganizing and re-establishing their services, and in re-equipping their institutions and agencies. The nursing personnel of missions therefore work only in administrative and consultative capacities.

If additional personnel are needed such recommendations will be made, but al-

ways world-wide needs and distribution of personnel must be kept in mind. It is not contemplated that a large number of nurses will be sent at any time.

IN accordance with the general policies formulated when the Office of Foreign Relief and Rehabilitation Operations was established, the staff of the Health Branch of OFRRO in Washington has been kept small. The main task of the Washington staff is planning and procuring personnel and supplies. There did not seem to be need for a permanent position for a nurse on this staff, but there was need for temporary nursing assistance and through the generosity of the Milbank Memorial Fund, Miss Hazel Goff's service was made available. Miss Goff's long experience abroad made her peculiarly fitted for the task of defining broad nursing policies and compiling information about nursing in the European countries.³ Though it was not known at that time when nurses would be sent overseas, a file of qualified nurses who were interested in this work was needed at once. This is in conformity with the general policy of OFRRO of establishing reserves of people qualified for all types of positions who can then be called upon short notice when needed.

First, key nurses in the country were asked to suggest names of other nurses who might be interested in this work. These nurses were then approached and asked to submit applications if they were interested and thus the reserve of nurses was started. Present plans foresee a need for nursing personnel in three different capacities requiring various degrees of education and experience. The senior nursing positions require at least five years of supervisory experience and also special education, either in public health or hospital nursing. Subordinate posi-

tions will all require the same professional education, and at least a year of supervisory experience. Knowledge of languages and travel or experience abroad is an added asset. In addition certain personal qualifications are essential. Dr. Crabtree further said in his talk to the Hospital Association:

I would again emphasize that the prime responsibility of these people will be to assist in the organization and strengthening of official health services and in gearing them to meet needs which in some respects will have no precedent in their history.

Although we cannot now foretell the number of American personnel that will be needed, we do have convictions as to what their general qualifications should be. They must be experienced in American methods of administration and well abreast of modern technics in medicine and hygiene, yet thoroughly tolerant of the technical points of view of their colleagues in other countries; they must be mature in judgment, yet physically fit to withstand the rigors of living and working in a war-torn environment; in undertaking their tasks, they must be motivated by the highest ideals of service, and not by mere considerations of adventure. Though their training over here will have been appraised in the light of their knowledge of refinements of American methods and technics, they must view the public health problems over there in the proper perspective of deep rooted cultural patterns and social institutions, and they must recognize the necessity, in many areas, for approaching problems at their very grass roots, where the very essence of public health, such as housing, agriculture, food and shelter must be taken into account and not, as over here, taken for granted; and, finally they must uphold the dignity to which each of them will have been lifted in the eyes of liberated peoples by the traditions of our democracy.

A TRAINING program is given all newly appointed personnel of all branches of OFRRO. This is planned to introduce the personnel to OFRRO, its setup, policies, relations with other agencies and its plan of operation. Members of the staff of OFRRO, and of other related

agencies, conduct these conferences. Various countries are studied briefly, so that a rough picture of their composition, geography, history, industry and health and welfare are covered. Language classes are also held daily. The entire program is planned to cover an eight-week period. Thus, during this time, personnel, already highly specialized in their particular fields, are given an introduction to the country where they shall probably be sent.

It is anticipated that nursing personnel will also have an opportunity to attend brief refresher courses on certain selected topics, such as tropical diseases and trachoma. As part of the training program a large bibliography of material is made available and many organizations who are experts in the various fields of activity have contributed. In the nursing field, the International Council of Nursing, the International Red Cross Nursing Service and individual nurses who know nursing in European countries, have already given and will continue to give invaluable aid.

Some impatience might be felt at the very general terms in which plans of operation have been expressed. But work of this kind cannot be planned with any specificity as to the mode of operation from a desk in Washington six months or a year ahead of time. It is difficult to get complete information here, and conditions change so fast that the field staff must have the responsibility of making the specific plans, and must be able to take general policies and put them to work in each situation as they meet it.

Dr. Crabtree has summed up the responsibilities of the health staff of OFRRO in terms of its larger significance so well that we quote again:

... Public health in all its phases is eminently suited to serve as one spearhead for the pro-

PUBLIC HEALTH NURSING

gressive movement toward an eventual world society of nations. As such it assumes a major role in meeting the challenge for a durable

peace. The vastness and drama of this challenge are second only to that of winning the war.

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SUGGESTIONS FOR APPOINTMENT OF NURSES FROM THE UNITED STATES FOR FOREIGN SERVICE

A COMMITTEE on Foreign Postwar Planning appointed by the National Nursing Council for War Service has carefully considered the problem of relief and rehabilitation in the light of its probable demands upon the nursing profession. The principles which seem fundamental to this problem and which in the opinion of the Committee* should guide the selection, appointment and conduct of nurses from the United States, are set forth in the following memorandum.

First of all, the guiding purpose of the relief and rehabilitation program is to help each country to help itself. This implies that appointments to service in nursing, as in the other specialized fields, will be of a temporary nature. Personnel from the United States will be withdrawn as soon as nationals are able to take up and carry on their work. It also implies that those assigned to foreign service must be able and willing to understand and respect the customs, conditions and values of the nationals among whom they work. If the ability of nationals to carry on is not correctly estimated, there is danger of prolonging the program unduly or, more likely, of abruptly withdrawing American personnel before the work is established and local leaders have been found.

An important part of the program should be to seek out among the nurses in foreign coun-

tries those showing qualities of leadership so that some may be selected for advanced study abroad when the time is right. Careful study of local nursing schools may point to assistance in nursing education as a cardinal contribution to rehabilitation.

Cooperation with recognized national and then local authorities in countries in which the work is being carried on, is essential to any successful relief or rehabilitation undertaking, and any attempt to force North American methods and objectives on foreigners should be studiously avoided. Adaptability, tolerance and respect will invite success, whereas rigidity, overassurance and the assumption of superior intelligence and training will evoke resentment and threaten eventual failure.

To insure cooperation with recognized national and local authorities, working relations must be early sought and harmoniously maintained with the nursing bureau or corresponding unit of the national ministry of health or department of health. Furthermore, assistance will be needed in the development and recognition of the local nursing profession. Such aid may be given through support of the national professional organization of nurses, through emphasis on generalized rather than specialized health service and through establishing a high reputation on the part of the nursing profession for cooperating with qualified relief and rehabilitation agencies.

Since the underlying philosophy is to help

*Working Committee on Foreign Postwar Planning: Mary Elizabeth Tennant, chairman, Hazel Goff, Hortense Hilbert, Edith Smith, Isabel Stewart.

(Continued on page 668)

Nursing at Palama Settlement

By LUCILE OTTO, R.N.



AFTER 37 years of service the doors of the nursing department of Palama Settlement are closed. This private agency which pioneered in public health nursing in Honolulu, Hawaii, combined with the Territorial Board of Health in 1929, and on July 1, 1943, gave over to it complete control. At this time public health nurses on the Island of Oahu were divided into two units and moved into two new health centers.

The story of Palama Settlement with its many changes since it was founded as a religious chapel in 1896 is a long and interesting one. The following account deals with its nursing service which started in 1906. In that year, the Free Kindergarten Association of Hawaii employed a nurse in their kindergarten. Palama arranged to use this nurse part time for home nursing among the poor.

When a milk depot was established at Palama this nurse took charge of dispensing free milk to needy babies. This was only the beginning of many additional duties. When she went into a home she did all she could that needed to be done. She not only gave nursing care; if the mother were ill, she gave the small girl housekeeper cooking lessons. She tried to carry on social work, and if a family affair had reached the belligerent stage, she called the police for help. She kept a small stock of clothing, donated by the needlework guild, which she distributed to needy families. At Thanksgiving, Christmas, and New Year's Day, she played "Lady Bountiful" by helping community organizations distribute baskets of food to needy families.

Two years later, an executive nurse and several field nurses were added to the Palama staff, full time.

PUBLIC HEALTH NURSING

A nursing service under the Territorial Board of Health was started in 1910, when the Board employed the first two nurses for tuberculosis work. At this time there were seven nurses on the Palama staff and the two organizations began to grow side by side. The city was divided into districts and four free dispensaries were opened by Palama Settlement in different sections. There were no doctors in these dispensaries. The nurse did first-aid treatments for the neighborhood and follow-up treatments referred by the Palama doctor. She kept a large supply of drugs obtained from the Palama Dispensary. She sold or gave cough syrup, castor oil, camphorated oil, and other medicines freely to patients on request. She was proud of her number of sales. The field nurse carried a small bag of drugs with her. If she did not have a drug which she thought the patient should have, she brought one of the children back to the dispensary for it. Standing orders were very flexible at this time.

ALMOST every morning a large group of patients would be waiting at each dispensary when the nurse arrived. She came trudging down the street with her stiffly starched uniform nearly sweeping the ground, high collar tightly pinned about her throat, a watch fastened on the front of her dress, and a wide, turned-up brim hat securely pinned to her piled-up hair. She went about preparing for the day while the patients formed a line and lazily gazed at the wall posters, with such mottoes as "Brighten Up" or "Keep Smiling." After her patients were treated, she closed the dispensary, carefully hanging out the home-made sign "Nurse Out," and went out into the district to make home calls or perhaps to visit one of the few schools under nursing supervision.

The school work at this time, and for many years to follow, consisted entirely of treatments. The nurse reported to the principal who blew a whistle dangling from a black ribbon around his neck. A monitor appeared who notified each teacher that the nurse had arrived. Children came streaming across the school yard to the dispensary. A long, wiggling line formed outside the door and the work began. Impetigo sores were dressed and re-dressed, eyes treated and medicine sold to the children, heads inspected and found in the same vermin-infested condition time after time, temperatures taken day after day, notes written to the mothers with poor response. Some principals considered the nurses were doing fine work because the line of waiting children was so long. As the school service gradually changed and the responsibility for the treatments given by the nurse was placed on the parents, a few older principals thought the nurse was not doing her duty under this new system. One of the nurse's duties was to check up on absentees and one day a small eight-year-old girl reported that the reason she was not at school the day before was because she had to help her mother "born a baby."

Another phase of nursing service began when a day camp, with a nurse in charge, was opened in 1910 for children from families where there was tuberculosis. During the 1920 influenza epidemic, all children were sent home except borderline cases who were transferred to the County Tuberculosis Sanatorium. Tents were put up on the camp ground and the nurse cared for the influenza patients.

As nursing work progressed throughout the community and more field nurses were needed, the limited Palama budget could not take on the added expense. The Chamber of Commerce agreed to pay the

NURSING AT PALAMA



In 1910 the Palama nurse dispensed first aid and cough syrup to the waiting line in the dispensary

salaries of a number of nurses, and generously assumed this responsibility until the Board of Health finally took it over last summer.

A "Fresh Air Summer Camp" was opened in 1914 at Waialua Beach across the Island from Honolulu. The first group to go were mothers with small children who needed a little rest. This proved such a success that a permanent camp, but only for children, was established. It was closed in 1930 after 16 years. Each summer a nurse was placed in charge of the health work at camp. The word "Fresh Air" hardly seems appropriate for this semi-tropical climate, but it was found that many of the children were accustomed to sleeping with all windows closed "to keep out the unhealthy night air." The Chinese believed that closing windows at night "kept out the devils." Many times parents and a large number

of children slept in one room. At the camp some of the children slept in night clothes for the first time. When one small boy was told to put on his night clothes, he carefully inspected his scanty two pieces of clothing and said "But these clothes aren't dirty yet." At the camp, clothes were washed by using them as swimming suits.

The nursing work expanded to such an extent that a nurse could no longer cover her district on foot. The driver of the limited streetcar service usually stopped at any point to save the nurse a few steps, but she often walked miles down narrow lanes, across taro patches, through weedy paths back into the valleys or up the rocky trails of mountain slopes. House numbers were scarce and sometimes when a family moved they took their mailbox and number along, which made it difficult to locate them.

PUBLIC HEALTH NURSING

THE YEAR 1922 was a year of real rejoicing, because two automobiles were donated to the nursing staff by friends of Palama. The year 1923 saw the beginning of child health work by Palama, sponsored by the Women's College Club. For years following, club members acted as volunteers at the child health conferences. Numbers were stressed at these conferences, and many times the nurse went wearily home after lifting 100 babies on and off the scales. A baby was weighed and if he gained the nurse said, "That is fine, come again next week." The doctor saw only those babies coming for the first time, those needing their formulas changed, or those which might need special attention. At these "Baby Clinics," some medicines were kept and prescribed.

The following year an obstetrical service was begun. It was difficult work, because for so many years the Hawaiians and Orientals had been attended by native midwives or some member of the family. They were afraid of doctors and hospitals. Many times patients came to the maternity conference once and would not return. After much questioning, a nurse would receive the frequent answer in the famous Island "pidgin English": "Too much shame, every time undress before man doctor." One nurse used the following method to build up conference enrollment. She would go into a camp or tenement section and ask where "Trengalina" lived. She was always a little vague about Trengalina's nationality or surname, but she was positive about her being *hapai*, which means pregnant in Hawaiian. She usually learned who all the "hapai" women in the camp were, even though the informant could not always give their names. The nurse proceeded to call on these women and invite them to attend the conference. The de-



The doctor tells a young family about tuberculosis

livery service was discontinued after a number of years, and a few years later both the maternity and child health conferences were taken over by the Maternal and Child Health Service Bureau of the Territorial Board of Health. However, the Palama nurses continued to staff them.

In 1925, when the entire Palama staff moved into the present spacious new Settlement buildings, a nurse could at last leave her desk without asking one or more nurses to tip their chairs forward in order to let her pass.

At about this time the Board of Health nursing staff was increased. They, too, had expanded and had had nurses on the other islands since 1921, but there was no coordination of services. Their title was changed to Public Health Nursing in 1923, and again to Bureau of Public Health Nursing when it was established with a separate budget and director in 1930.

The nursing work was divided and the Board of Health took over the school work and continued the followup of tuberculosis cases. Palama nurses carried

NURSING AT PALAMA

on all other services. With special maternity nurses and field nurses from Palama and the nurses from the Board of Health, one family would sometimes have three nurses visiting them, each for her own particular service. Once a mother complained to the third nurse to call in one day, "This morning one nurse came to show me how to fix a tray for my new baby. Then another nurse came to see why Leilani didn't come and get weighed last Tuesday. Now you come and say David must have his tonsils out so he won't miss so much school."

AS A RESULT of the survey by Dr. Ira Hiscock in 1929, the two nursing organizations were combined on September 17, 1929, still under two bureaus, and nursing was placed on a generalized basis. At that time, the Palama staff consisted of a director, an educational director, two field supervisors, and 17 field nurses. The Board of Health staff included a director, one field supervisor and eight field nurses. Then followed a period of adjustment of records which had to be revised and expanded to meet the needs of rural and urban areas, and an official and a nonofficial agency. This adjustment was brought about in the following manner:

A council of the directors and supervisors of both agencies held weekly meetings. The education director of Palama and the field supervisor of the Board of Health worked together as a committee to formulate tentative policies, techniques and records which were then presented to the council at these meetings. The American Public Health Association appraisal form and the National Organization for Public Health Nursing records were used as guides. A steady stream of correspondence was carried on from the Supervisors' Council to the NOPHN, and much help

was received from the National at this trying period. Tentative plans were revised by the Council, after which they were presented to the staff members of each organization. Copies were also sent to supervisors of the outside islands, who in turn presented the plans to their staffs. The results were pooled and the final policies, techniques and records devised. In some cases, new records were first used on a trial basis in certain districts; if found satisfactory, they were adopted for use in all districts. The supervisors took turns in recording minutes of the Council meetings, and later they rotated as members of the Committee. At the request of the Supervisors' Council, representatives from related community agencies met with the Council to work out inter-agency relationship policies.

When the first public health nursing course in the Territory was given at the University of Hawaii in 1932, Palama loaned the education director part time to organize and direct the course. Later, a full-time director was employed by the University. The students were given their field experience by the combined nursing service. Later, the Queen's Hospital Training School students were given two months' affiliation with this service.

Some years after the combination, the volunteer nurses in parochial schools were replaced by public health nurses and these schools were added to the public schools carried in the generalized program.

In 1940 all Honolulu Board of Health nurses moved from the Territorial Building to Palama Settlement and a sub-station. They were placed under the supervision of one director, who was made an agent of the Board of Health although she was on the Palama payroll.

The gradual withdrawal of Palama

PUBLIC HEALTH NURSING

from the nursing service began in July 1941, with the transfer of 10 Palama nurses to the Board of Health payroll, as provided for by the Territorial Legislature through an increased appropriation for the Bureau of Public Health Nursing. In December of the same year, when the Palama director resigned, she was replaced by a director under the Board of Health. At this time the rural nurses on Oahu were placed under her supervision. This appointment nominally put all of the remaining Palama nurses under the Bureau of Public Health Nursing, and

their identity as a separate unit gradually became a thing of the past.

December 7, 1941, found a united staff ready to meet the emergency and to take on added burdens of helping in evacuation centers, immunization clinics and followup of unusual numbers of cases of communicable diseases.

When the nine Palama nurses, and those under the Board of Health, left the Palama office which had been home to some for 20 years, it was with a host of happy memories and the looking forward to adding more such memories to them.

Tuberculosis in Wartime

(Continued from page 654)

a continuously declining death rate.

It is estimated that at least 25,000 previously unreported cases will be discovered prior to January 1944. With restricted sanatorium facilities these cannot all be hospitalized. This points toward a notable increase in the open cases which must be cared for in their homes. On the public health nurse's shoulders falls the extra work which this situation involves. Can she meet the emergency? The answer is, of course, in the affirmative since public health nurses have never yet failed in service to their communities. But only by some reorganization of schedules and maximum economy of time can this be accomplished.

From these facts it is obvious that it is wholly unwarranted to consider that epidemic tuberculosis is under control. For the duration, and after the war, our defenses must not only remain intact but

will require reenforcement if we are to hold our own against this disease. Despite the care with which the tuberculous are excluded from the armed forces, active cases are already being discharged from the services at the rate of more than 300 a month. This is ample proof of the infection's insidiousness and of its disastrous collusion with war.

The public health service is keenly alive to the menace. A strenuous effort is being made to impress on the depleted medical profession the responsibility of every member to employ known methods of early diagnosis in his practice. With the public health nurse realizing to the full the significance of her contribution and carrying her extra load we may still forestall the expected rise in tuberculosis and establish a new wartime record in the protection of the nation's health.

KENDALL EMERSON, M.D.

MANAGING DIRECTOR
NATIONAL TUBERCULOSIS ASSOCIATION

Play Materials in the Home

BY CLARA OSGOOD, R.N.

WHAT SHALL I do now, mother?" How often have we heard this question and haven't we answered, "Oh, go and find something to play with." Do we recognize play as the child's means of growth? Are we accepting this challenge?

It is these first formative years of the child's life that will lay the foundation for the man he is to become. It is the kind of guidance we are giving the children in our land today that will do most for the better world for which we all hope. If we stop to consider what constitutes the largest part of a child's life, we discover that it is his toys and his playtime. Every child passes through several stages of growth. He has special needs at each stage. If we understand these needs, we can utilize them in guiding him toward a richer life.

Everything in a child's environment is play material. Toys will always be bought in the spirit of fun, for they are gifts for children, but correct toys only increase and never detract from their fun. Toys are the treasured possessions of the most impressionable years of our lives. Toys can turn the activities of children into productive and creative channels or into those which are destructive and selfish. Let us look about our homes and see what we can offer our children to ensure them good playthings.

For convenience in selecting play material, we will classify it according to the age of the child, needs of this age, and raw materials in the home to suit each

group. No classification of this kind can be anything more than a wide swinging base to work from, varying with each individual child, but nevertheless showing a certain continuity in development. Fortunately a few basic guiding principles aid in the selection of all toys.

1. Toys that give a chance to "do with" and do not make the child a spectator (Mechanical toys are poor according to this principle)
2. Durable toys
3. Hygienic and sanitary toys
4. Play material that fits the level of maturity of the child
5. No ugly toys

All through the preschool years there are two factors of growth to guide us: (1) the development of his senses and (2) the development of his muscles so that he can handle and control himself and his environment.

If our child is the newborn baby, there are several things we will want to know. Very soon we will notice that he "listens." In two or three months he will begin to follow objects with his eyes. He is discovering his environment. As he kicks and squirms he is discovering himself—his hands, his feet. When he is about four months old he has a ravenous touch hunger. He wants to grasp, and feel and manipulate everything that he sees. The first six months the baby is learning to play. Do not interfere unnecessarily with his movements. Have clothing that will not hamper him. Have a short play period each day with the baby undressed. Just before the bath is a good time or that fussy late afternoon or evening hour.

He will kick his feet and wave his arms. Later, he will roll over, and at about six months he will begin to try to sit up. He is gradually discovering what he can do with his body. If we allow him this freedom, we are fulfilling one need of this period.

In choosing his play materials, there are several helpful points to know in addition to the principles outlined for selection of all toys. The "toys" should be simple, light weight, easy to grasp, able to withstand investigation, washable, and those that can be put in the mouth.

For the sense of touch:

- Soft things—
 - Washcloth doll
 - Stocking doll
 - Stuffed balls made of powder puffs
- Smooth things—
 - Oilcloth stuffed animals
 - Cloth scraps
 - Bottles (when being watched)
- Light things—
 - Empty tins and boxes
 - Mailing tubes
- Hard things—
 - Blocks of wood (various sizes)
 - Keys on a ring
 - Cloth stuffed ball
- Rough things—
 - Beanbag
 - Corrugated cardboard box
- Heavy things—
 - Boxes filled with sand, dirt, or salt

For the sense of sight:

- Bright pillows to look at
- Dangling bright pieces of cloth

For the sense of hearing:

- Teaspoon and kitchen pans
- Sealed can with pebbles inside
- Scrap paper to crunch (bright handbills)
- Bells
- Music

A miscellaneous list of materials that are valuable for development of senses as well as muscles used in reaching, grasping, and manipulating:

- Spools on string (can be strung across crib)

Clothespins (one or more with or without basket)

Household utensils such as nested measuring cups, spoon and cup

Paper bag doll

At about nine months of age the baby will begin to be interested in those little nursery tricks of "How Big," "Pat-a-Cake," and all the many things of this kind that are such a delight both to the mother and father and to the baby himself. At about this time too, the baby's muscles are getting strong enough so he can sit alone and he needs a firm surface for support. He should be taken from the limited play space of the crib and carriage and put on the floor, either in a play pen, or an enclosure made by chairs laid down on their sides and placed end to end. The baby has a great sense of pleasure and feeling of self-confidence when he finds that he can stand alone. Let him have the fun of learning to do things himself. Do not anticipate his movements.

When the baby begins to walk, his opportunities for play widen. There is probably no year in a child's life when he learns so rapidly as this first year of toddling and running about. And no year is so difficult for the mother unless approached with understanding. When he begins to walk the child is "into everything." Many tragedies can be averted if the precious knickknacks and valuable home furnishings are put out of reach. The child must have opportunity to learn about his environment, but he need not do it at the expense of destruction of beautiful things.

The interests of this age are a continuation of those of the first year, but the greatest need is for exercise toys. By now, toys are becoming something more than things to handle and feel. Now our children begin to "play" with the toys. Let us remember to let the child use the

toy for the kind of play he finds most satisfying. When a new toy is given to him, we should show the possibilities it permits and then let the child use it as his imagination suggests.

Exercise toys (valuable throughout pre-school years)

For balance

Slanting board or cellar door to run or slide on

Sturdy board nailed across low boxes (10 or 12 inches wide)

Rocking chair

Swing (first with attached seat)

Boards and saw horse for seesaw and incline

For climbing

Stairs (first with a railing)

Chairs

Packing boxes of various sizes

Ladders

Miscellaneous

Wheelbarrow

Rope

Wooden box on casters for wagon

Toys for the one-to-three-year-old

Push and pull toys

Cardboard and wooden boxes with string attached

Round cereal boxes with long wooden handle

Tin can with 2 holes in center of ends and a coat hanger with padded end inserted for pushing or a rope for pulling

Wooden box with wheels and a handle for filling and dumping

Manipulative toys (things to put together and take apart, or to fill and dump)

Coffee can and clothespins to pin around edge

Blocks (small 2-inch, bright colored)

Nest of boxes (plain bright colors)

Sand box or dirt or snow and a spoon or shovel

Water playing—washing clothes; "painting" with large brushes; wood, peapods, walnut shells for boats

Wastebasket

Large boxes for building

Boxes to open and close

Cans with screw tops

Wooden spools and shoe string with metal tip

In the three- to five-year-old we see a

continuation of finer muscle development, and the beginnings of real creative play. He will take up a discarded toy for a new use. And the same play material will be used in many different ways. At about this time, group activity begins. The child who before this time would play in a group but always independently, will now join in play with others. This is an important period of social adjustment. For the first time the child is learning how to get along with others. Up to this age he has been learning how to handle things, but from now on he recognizes himself as a part of society.

Toys for the three- to five-year-old

Exercise toys

Narrow board on ground (width of shoe or less)

Kegs

Single rope swing with knots at about 9-inch intervals

Barrel hoop

Kites from bright colored wrapping paper

Material for imitative and creative play

Putty left from repairing windows (if mixed with paints instead of water, colored putty can be made)

Store material—tin cans, boxes, and buttons and paper for money

Wall paper sample book, or wrapping paper for scrap books, blunt scissors, old magazines, colored paper, and paste (flour and water)

Large-piece puzzles made by pasting pictures on cardboard or wood and cutting them out

Clay substitute—cut paper into 1-inch squares, soak in water over night until soggy, pour off extra water. Now it can be molded

Sewing materials—old scraps of cloth, cardboard with holes punched to outline a picture and yarn to sew outlines

Housekeeping toys—dishes, broom, bright cloth

Costume box—old dresses and clothes

Doll furniture made from cardboard or wooden boxes

Wrapping paper, paints and large brush

Tent made with chairs and old blankets

Spool for soap blowing

PUBLIC HEALTH NURSING

Nails, hammer, soft wood
Gardening tools
Packing box for house
Pets—puppy, fish, kitten
Blocks (smooth wood) An ideal set to allow greatest variety of play includes:
12 blocks— $3\frac{3}{4} \times 3\frac{3}{4} \times 3\frac{3}{4}$ inches
24 blocks— $3\frac{3}{4} \times 3\frac{3}{4} \times 1\frac{7}{8}$ inches
12 blocks— $7\frac{1}{2} \times 1\frac{7}{8} \times 1\frac{7}{8}$ inches
24 blocks— $7\frac{1}{2} \times 3\frac{3}{4} \times 3\frac{3}{4}$ inches
12 blocks— $15 \times 3\frac{3}{4} \times 3\frac{3}{4}$ inches

An "odds and ends" box
Old newspapers for soldier hats, et cetera
Tin cans, bottles, boxes
Picture postcards
Paper bags for masks, et cetera
Bright linings of envelopes
Magazines
Yarn
Cord

And now at five or six years of age when we see our child set up store and bargain with his customers, or watch her dress up and serve tea to her friends we see that the years of play have been of infinite value. He is learning skillful co-ordination of senses and muscles and the lasting pleasure that can only delight from being able to do something with whatever material is at hand. He is going to know how to make happier use of his leisure time in his adult life because of this intelligent early guidance. Every individual has to learn to get along with things and people. Toys represent the things and other children the people. As he plays so will he live.

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Nurses for Foreign Service

(Continued from page 658)

each country to help itself, the nursing personnel selected for work abroad should be women whose professional education has endowed them with this point of view. Maturity of judgment will be essential in their work. The task will be arduous and demanding, and upper limits of age should be considered in this light. Good health and emotional stability are essential, as well as an ability to adjust readily to new and different customs. Also important in the personality of the appointee to foreign service are good sense, good humor, good manners and good faith. Knowledge of at least one foreign language is desirable, and it is imperative that nurses working in any foreign field be able to speak English clearly and distinctly and to express themselves in simple, effective terms.

Because of the complexity of the problems involved and the extent of the services to be

rendered, the nurse in foreign service should have a cultural background such as may be provided by a liberal college education. She must be a graduate of a state accredited school of nursing which provides instruction and experience not only in the four basic services—medicine, surgery, pediatrics and obstetrics—but also if possible in the fields of psychiatry, communicable diseases, tuberculosis and orthopedics. She should be a registered nurse. Advanced preparation in the special field to which she will be assigned is also necessary. No nurse should be entrusted with work in foreign service who has not demonstrated ability in her work at home. Familiarity with the underlying principles in the establishment of nursing organizations and with the resources of both national and international associations, is essential. Inasmuch as any type of nursing work abroad will involve a knowledge of both nursing education and public health, workers should be prepared to assist in either field.

The One-Nurse Service Adjusts to Wartime Needs

By RUTH E. MURPHY, R.N.

THE SPREAD of venereal diseases, the potential rise of tuberculosis, the need to keep all communicable diseases in check, the increasing number of war brides in need of maternity care, sanitation problems brought about by the congestion in war centers, limitations in transportation facilities, loss of personnel—these are just a few of the big problems faced by public health nurses today. These urgent and complex problems point to the need for swift and sane action on the part of all health workers. That we are fulfilling our purpose in the community and that our efforts and services are contributing directly to the war effort is a matter for pride. Any other justification at this time is not worth while.

In the State of Missouri the members of the Division of Public Health Nursing together with the directors of the Divisions of Local Health Service, Maternal and Child Health, Venereal Disease Control, Dental Health, and Public Health Engineering carefully studied the various services to determine where the greatest emphases should be placed during the war emergency. Their suggestions sent to local areas, we call our "War Emphases in the Public Health Nursing Program."

In this material suggestions were presented which serve as a guide and measuring rod in planning and executing the public health nursing program. The local

health departments made adjustments in their programs according to existing resources, problems and needs. What Randolph County did is the subject of this story.

UTILIZING AVAILABLE NURSE-POWER

The immediate need was to utilize existing nurse-power effectively and efficiently. Randolph County first began a program to accomplish this in the organization of Civilian Defense. A local inactive nurse was appointed zone nurse, covering an area of several counties. She works along with the medical chief of the Emergency Medical Corps. She in turn appointed a chief nurse, covering our county. This chief nurse after much publicity secured a registry of graduate nurses in the county. A meeting was held and 33 nurses attended. Out of this group, the Randolph County Registered Nurses Association emerged. They became interested in doing their part on the home front and volunteered their services to the public health nurse, thus releasing her for more important duties. When the services of these nurses are needed by the public health nurse, the chief nurse is called and she assumes responsibility for making all arrangements to have a nurse or nurses available, whatever the need may be.

These nurses assist with venereal disease clinics, child health conferences and

PUBLIC HEALTH NURSING

immunization clinics. They assume the duties related to assisting the doctors, thus leaving the public health nurse free to supervise immunization and to interpret and reassure in the venereal clinics and child health conferences.

The Emergency Medical Corps is complete and working. For example, these nurses responded quickly to a call when a first-aid station was needed at the scene of a large fire and there was danger of gasoline tanks exploding.

TIME SAVING DEVICES

The use of letters has helped save the nurse's time, and also assisted her in selecting a case load. This is especially true concerning army referrals of men infected with venereal disease and contacts of venereal disease and tuberculosis cases. We have found that the majority respond to a letter by a visit to the nurse's office, thus saving the time that might have been spent trying to locate them. Recently a venereal infection was reported on Wednesday of one week. A letter was mailed to the patient asking him to appear at the nurse's office at a given time, which he did. Arrangements were made and the patient was under treatment by the following Wednesday.

It sometimes becomes necessary to make night calls on rejectees who work during the day. The nurses also keep office hours on sale day when rural people are in town. Together with careful zoning of the county these arrangements help to keep travel time at a minimum.

During wartime there is always an increase in venereal disease. It is the duty of the public health nurse to plan carefully the follow-up work on all cases. This has become a much easier task with the use of the chart classifying urgency and method of follow-up according to the stage of the patient's infection and the

number of arsenicals administered to date. This chart and a similar one for following up tuberculosis cases are included in the "War Emphases" program.

HEALTH PROGRAM IN THE SCHOOLS

During the past winter each school was reached by an immunization program, needed at this time to re-emphasize the preventive aspects of illness. The school boards and county superintendents of schools did much to interest the school authorities in promoting the immunization clinics. The teachers did their part by urging all parents to be present, thus presenting an opportunity for group teaching. This gave the public health nurse a chance to talk to parents and stress the importance of immunization. As a result of combined efforts many children in the schools were immunized against smallpox and diphtheria.

The health chairman and members of the parent-teacher association also spend much time and effort with the school program. Their assistance at child health conferences and school immunization clinics have been a great help to the nurse. They organize the clinics, recruit volunteers, assign them to their duties, secure the physician and dentist, and make home visits to urge parents to attend with their children.

To spread her influence widely in the schools, the public health nurse attends teachers' meetings each Fall to demonstrate and discuss weighing, measuring, visual acuity testing, hearing testing, continuous health observation, hot lunch programs, and handwashing drills. The teachers are used as students in these demonstrations. Individual problems of the teachers are talked over in teacher-nurse consultations when the nurse visits the school by appointment or when the teacher calls at the nurse's office.

ONE-NURSE SERVICE

County nurses help meet the nationwide nurse shortage by guidance to young women desiring to enter schools of nursing



NURSE RECRUITMENT

In conjunction with the General Federation of Women's Clubs, a booth has been established in the business district of the county's largest town for the recruitment of student nurses. A club member answers questions concerning the scholarship funds available from the women's club and a nurse answers the applicant's questions concerning the advantages of nursing, its requirements, and nursing schools. This booth is open two days a week for a two-hour period. In addition, a volunteer nurse keeps a shelf of recruitment literature in the library for the benefit of girls interested. To date 17 girls interested in nursing have been interviewed. Of this group two have already entered schools of nursing, one has had her pre-entrance physical examination, six have placed their applications, and one married girl with two years of training has re-entered to finish her training, her husband having entered the armed forces. This project began in May. In this way Randolph County is doing

its part to help fill the gaps in the civilian nursing ranks which have been made by the many leaving for service with the armed forces.

Recently, one of the inactive nurses has become "Recruitment Nurse" for the Red Cross. Randolph County has contributed seven nurses to the armed forces.

TEACHING HOME NURSING

Six inactive nurses teach home nursing in rural areas and towns throughout the county. Five hundred nursing certificates have been issued since Pearl Harbor. Last year 46 certificates over the quota were issued for the year. Each instructor encourages her class to make some contribution to the public health nursing loan closet and in this way the loan closet has become a large and useful project in the county. A surgical nurse in a local hospital volunteered to sterilize the obstetrical bundles for the closet.

At the present time a plan is being worked out with the home nursing chairman to use volunteer home nursing cer-

PUBLIC HEALTH NURSING

tificate holders in the public health nurse's office. Their duties are to be as follows: clerical assistance, typing, answering telephone and receiving messages, acting as receptionist at child health conferences, preparing demonstration material for home nursing classes, replenishing supplies for clinic use, pulling and filing records at well-baby conferences, arranging rooms for clinics and putting rooms in order afterwards, checking supplies in and out of the loan closet, and contacting those who have borrowed and not returned articles within a reasonable length of time. Some of these duties have been carried out by a nurse's aide and campfire girls wishing to give their time. The nurses feel that these volunteer groups should have careful supervision and planned instruction in order that professional responsibility be maintained.

The Randolph County Advisory Council plays an important part in the public health nursing program, although due to gasoline rationing they can now meet only once every two months. Council mem-

bers' husbands or wives are also invited, as we find the attendance much better when the couples may attend together. We usually have a covered-dish dinner. Among other responsibilities this organization is seeking methods of making funds available to the public health nurse for corrective work. They attend to all possible minor details of the nursing service which ordinarily would take up the nurse's valuable time.

We, as public health nurses, should be vigilant and heedful of our responsibilities. We should give forethought to the objectives of our program so that the communities we serve will receive the assistance required.

The role of the public health nurse in the war emergency program is of vital importance. It is her duty to assist in maintaining a civilian population which is physically and mentally strong. Her assistance in a preventive program, from the immunization of the infant to the bedside care of the sick, contributes to the well-being of our boys in the front lines.

PALAMA NURSES HONORED

FOUR PUBLIC health nurses who had given from 18 to 20 years of service to Palama Settlement were honored in October by the Settlement with life memberships in the National Organization for Public Health Nursing upon the occasion of the transferral of the Settlement's public health nursing service to the Territorial Board of Health.

The nurses are Laura Hooker, May Bowron, Rachel Blyth, and Lucile Otto. Miss Otto, a graduate of St. Luke's Hospital, Kansas City, Missouri, has served in varying capacities at Palama, for the major part of the time as supervisor. She has been closely connected with the administrative changes there and in the words of Mary Williams, director of the Bureau of Public Health Nursing, Territorial Board of Health, "has helped to make the transition from Palama Settlement to the Board of Health a satisfactory procedure." A history of Palama's 37 years of public health nursing by Miss Otto appears in this issue (page 659).

A graduate of Lexington Heights Hospital, Buffalo, New York, Miss Hooker served overseas and in the Army in Hawaii in the last war and mustering out accepted a public health nursing position with the Settlement where she remained up to this year. Miss Bowron is a graduate of Wesley Memorial Hospital, Chicago, Illinois. She has been interested in Home Mission work all her life. Through her close association with the Hawaiian people she has come to be known affectionately as Mother Bowron. Leeds Training School, England, gave Rachel Blyth her basic preparation in nursing, and she has been with the Settlement since 1922. Her work among the people has been a valuable contribution to public health nursing in Honolulu.

Unexamined Tuberculosis Contacts

By BERWYN F. MATTISON, M.D.

THE PRESENT world conflict has brought with it an increased tuberculosis mortality. This comes at a time when civilian public health personnel is being depleted by the needs of our armed services. Routine X-raying of men inducted into the armed forces has been a great step forward. But to stem this rising hazard and avoid the army of civilian as well as military pulmonary cripples usually following in the wake of war, will require intensified efforts in all our routine control measures.

Of all population groups, with the exception of those already sick with respiratory symptoms, the contacts of known tuberculosis patients are most productive of new cases. This productivity varies with the type of case with whom they have been in contact—and recent studies have shown over 7 percent of active tuberculosis among the household associates of sputum positive or fatal cases.

Likewise, we know that among these contacts we will find more cases in the older age groups. It is easier to get the youngsters examined, but it is the "oldsters" who present our principal reservoir of infection.

It is obviously of first importance to secure the examination of a group which we have found to be so suspect. Yet, time and again, such contacts simply refuse to take advantage of the facilities available for determining if they have suffered from the special danger to which they have been subjected. Such refusals are apt to seem irrational and annoying. To

overcome them, some analysis of their motivation is needed. A knowledge of the causative factors should serve as a basis for reducing their frequency.

OF COURSE there are some defensible reasons advanced by people refusing to be examined for tuberculosis, but in many instances these have been partially solved. Where a working man cannot take time off to attend a clinic in the day time, evening sessions may be held. Transportation, once a major problem in rural areas, was pretty well arranged by volunteer agencies until gasoline rationing came along. Now this latter problem is again with us, lessened only by the fact that traveling clinics are being expanded wherever possible. In the case of invalids confined to their homes, portable X-ray units have been used to check their lung conditions.

A certain portion of the problem, we must admit, lies with the physician. There are not too frequent instances where contact examination is deemed unnecessary by the family doctor. In most of the situations where this occurs the individuals are in contact with a minimal, equivocal, or inactive case. True enough, there is little chance of the known case infecting the others, but where did *he* get his infection? It may well have been picked up years earlier from one of those who are now his contacts even though they appear perfectly healthy. When it is explained to the doctor that not only must the contacts

PUBLIC HEALTH NURSING

be protected against the diagnosed case but also eliminated as potential source cases, he will usually cooperate in securing such examinations.

There are also a few instances where the diagnosed case is the cause, directly or indirectly, of failure to get his contacts X-rayed. This may be because he does not want them to know of his diagnosis, or because he has not been told what he has and the others in his family cannot get away to the clinic without revealing the secret. In the first case, so ill-judged a viewpoint can often be changed by emphasizing the danger to his household caused by such an attitude; in the second, if circumstances really justify continuing the deception, arrangements can usually be worked out for the family to secure an X-ray without telling the patient of it.

However, when all these are cleared away, there is still a sizeable residue who refuse to be examined. A few of these may be illiterate and superstitious—unable to comprehend the situation and its implications. But most of them are apt to be otherwise average citizens. They give a variety of excuses, some good, some poor; they "*know* they haven't got TB"; or they "can't afford to have TB"; or they "don't want to know about it if they *have* got TB." Sometimes they give no excuses, promise glibly (time after time) to show up at the next clinic, but never do so.

ARE THESE people as irrational as their actions and excuses make them appear? I think not. Let us stop for a minute and look at these problems through the layman's eyes. After all, tuberculosis is a unique disease in many respects.

First of all, no other disease with which people in general are familiar can pro-

gress so far without making the patient *feel* sick. For many years the "White Plague" has been one of man's worst killers. Is it not natural for the layman to interpret it according to his experience with other serious diseases: pneumonia, scarlet fever, diphtheria, rheumatic fever—all of the others make their victims ill before they are sufficiently advanced to be diagnosed. How senseless it must seem to one who still remembers friends or relatives dying from "consumption" to be told he may have that disease and still feel well. The late symptoms of tuberculosis are well known. A productive cough, emaciation, blood spitting, night sweats, extreme weakness—these represent tuberculosis to many of our older generation. They are, therefore, being perfectly logical when they say so frequently, "But, Doctor, I feel all right. I *can't* have TB."

Secondly, as to the consequences of being diagnosed tuberculous. Here again the layman forms his conclusions on the basis of his experience. We cannot, unfortunately, deny that a majority of patients diagnosed in the past have not been promptly cured. On the contrary most of them have been discovered relatively late so that even when hospitalized and every treatment provided, months or years of invalidism resulted. Nor can we brag about the permanence of our "cures." These are the facts which make up the picture of tuberculosis evoked when an adult contact considers the possibility of being infected himself. And the older he is the blacker the picture will be if based on his own observations.

We know of the encouraging recent shift toward earlier diagnosis. We know of the work done by various groups, showing a fine percentage of relatively short term rehabilitation, especially in minimal cases. But the layman does not

UNEXAMINED TUBERCULOSIS CONTACTS

know these things. And once more, going on what he has seen, it is perfectly logical for him to say, "There is no cure for tuberculosis, so if I have it why be X-rayed?"

These two reasons—the certainty that if one feels well he must be well; and the feeling that nothing positive can be done to cure the disease once it is diagnosed—recur again and again after all other arguments are broken down or explained away. These appear to be the two elemental misconceptions on which rest a great many of these (otherwise senseless-appearing) refusals to cooperate.

CORRECTION of the situation will be difficult. Public education as to the frequency of asymptomatic disease must be slow, for the concept of symptomatic tuberculosis has been sturdily built over many years, and probably only after newer and better case-finding methods, such as mass X-rays in selected groups, result in earlier spotting of cases, or after the discovery of a new therapeutic agent, will public confidence in the curability of tuberculosis be soundly developed.

However, by keeping in mind these concepts and by attempting to explain away their faulty bases at the first visit—before the contact voices them—less resistance will be encountered later. There are several ways of going about this, and the approach used must, of course, vary with the individual and the community. As to the first point, sometimes the already diagnosed case may be used as an illustration. If it was an asymptomatic one, the point is already proved. If symptoms were present for but a short time, yet the physician has expressed the opinion that the disease is of considerable duration, this should be brought out. Sometimes figures are avail-

able from the local sanatorium as to the number of cases being admitted without any serious symptoms. On occasion a trip to the sanatorium to visit the diagnosed case may be used to point out how many of the patients seen there appear perfectly healthy. And so on.

Similarly, to bring home the fact that tuberculosis can be cured, no one approach will suffice. Sometimes there have been other members of the family who have "cured" successfully. Or it may be that a few experiences of the nurse with patients who have done well under treatment will help. Again, it should be pointed out that if the contact individual does feel well it is unlikely that any advanced lesion exists, and achievements by the local tuberculosis hospital or clinic in the treatment of early cases may be quoted.

ONE OTHER point must be stressed. The examination of each contact individual should be regarded as urgent. If he fails to come in when first advised to do so, he should be seen again soon (days, not weeks or months later). For when several months are allowed to elapse, if he has been inclined to use either of the arguments mentioned above, that passage of time without any tangible ill effects will confirm in his own mind the validity of his views. Consequently, the farther we get away from the time of diagnosis of the original case, the less productive are our efforts in securing contact examination.

This does not mean that uncooperative contacts can be forgotten. They should always be kept in mind as an unsolved problem and a potential hazard. It does mean, however, that in apportionment of nursing time, an hour spent in an intensive *early* effort to secure contact examinations is worth more than an hour

PUBLIC HEALTH NURSING

spent in a similar attempt later on.

To summarize briefly: Tuberculosis contacts, even though they refuse to be examined, "are still people." They have reasons for their refusal, which like our own rationalizations, may be good or bad. Usually they are based on lack of knowledge—most frequently a failure to realize

that early tuberculosis is usually asymptomatic or that modern treatment is producing many permanent cures. By stressing these two points in terms of personal or local experience, and by doing so immediately after the diagnosis of the original case, resistance to being examined can be reduced to a minimum.

SCHOLARSHIPS FOR POSTGRADUATE EDUCATION

Bolton Act funds have been allocated to 32 colleges and universities for all-expense scholarships in postgraduate programs in nursing education including public health nursing. Additional applications are still under consideration. This announcement comes from Lucile Petry, director of the Division of Nurse Education, U. S. Public Health Service, Federal Security Agency. Miss Petry points out that these scholarships are available to graduate nurses who show an aptitude for teaching and for public health nursing, and to those nurses now on staffs who are in line for advancement, or who feel the need of additional courses.

The following colleges and universities have received allotments:

California—University of California, Berkeley
California—University of California, Los Angeles

California—San Francisco College for Women, San Francisco

Colorado—*University of Colorado, Boulder
District of Columbia—*Catholic University of America, Washington, D. C.

Illinois—*University of Chicago, Chicago

Illinois—Loyola University, Chicago

Indiana—University of Indiana, Bloomington

Massachusetts—*Boston University, Boston

Massachusetts—Simmons College, Boston

Michigan—University of Michigan, Ann Arbor

Michigan—*Wayne University, Detroit

Missouri—*St. Louis University, St. Louis

Minnesota—*University of Minnesota, Minneapolis

New York—St. John's University, Brooklyn

New York—*New York University, New York

New York—Syracuse University, Syracuse

New York—Teachers College, Columbia University, New York

New York—*University of Buffalo, Buffalo

New York—*University of Rochester, Rochester

North Carolina—University of North Carolina, Chapel Hill

Ohio—*Western Reserve University, Cleveland

Oregon—*University of Oregon, Portland

Pennsylvania—*Duquesne University, Pittsburgh

Pennsylvania—University of Pennsylvania, Philadelphia

Pennsylvania—*University of Pittsburgh, Pittsburgh

Tennessee—George Peabody College for Teachers, Nashville

Tennessee—*Vanderbilt University, Nashville

Texas—*Incarnate Word College, San Antonio

Virginia—Medical College of Virginia, Richmond

Washington—*University of Washington, Seattle

Wisconsin—*Marquette University, Milwaukee

Other types of postgraduate courses and the institutions at which they are available are: Supplemental Clinical Operative Aseptic Technique, Yale University, New Haven, Connecticut; Supplemental Clinical Pediatric Nursing, Children's Hospital, Washington, D. C.; Midwifery, Frontier Nursing Service, Wendover, Leslie County, Kentucky, and Maternity Center, New York City; Anesthesia: St. Mary's Hospital, Duluth, Minnesota; and University of Minnesota, Minneapolis.

Nurses interested in securing scholarship funds should write directly to the school of their choice.

*Those which are starred offer advanced courses in some fields of clinical nursing or supervised practice in clinical fields.

VOLUNTEER - OF - THE - MONTH

She's
a Nurse's
Aide



Elizabeth M. Walleck

THIS IS THE second in a series of stories about services in wide variety which thousands of volunteers are giving to public health nursing agencies.

Volunteer for this month is Elizabeth M. Walleck of Pittsburgh, Pennsylvania. She is a Red Cross nurse's aide, up to November 1943 credited with close to 1,000 hours of service. For almost a year Mrs. Walleck has placed a substantial part of her time at the disposal of the Public Health Nursing Association of Pittsburgh, assisting with home visiting and other useful activities.

Mrs. Walleck's career as a volunteer began in a community house on Pittsburgh's North Side. At first she was put to work on the "odd jobs" which used to fall to the lot of the volunteer. Eventually someone discovered her talent for handicrafts, so in line with sound per-

sonnel policy she was asked to participate in the realm of her chief interest and ability—teaching handicrafts. Later she served as handicraft supervisor at the Pittsburgh Day Camps for underprivileged children.

After December 7, 1941, the tools of handicraft gave way to the tools of first aid—the splint and the bandage. Mrs. Walleck gave some 300 hours teaching first aid for the Red Cross. She says it was this connection that first put the nurses' aide idea in her head and the desire to help in the care of persons who are actually sick. She attended an accelerated day class at the Montefiore Hospital and became a full-fledged member of the Volunteer Nurses' Aide Corps in August 1942.

Even professional nurses whose own wartime programs are overlaid with

PUBLIC HEALTH NURSING

extra responsibilities will marvel at the schedule that Mrs. Walleck follows as a volunteer. Besides cleaning house, cooking meals and shopping, it includes all-day all-week service at the Public Health Nursing Association and other health agencies. And here a word of appreciation is due Joseph F. Walleck who has steadfastly encouraged his wife in her work as a nurses' aide, even though her volunteer duties have meant late dinners and busy work with the vacuum cleaner on weekends. Among the unsung heroes of today are the husbands of volunteers.

"Working with the Nursing Association," Mrs. Walleck says, "has done wonders for my self-confidence. Although there is a careful check by my supervisor on all that I do, often I am left to my own resources while in a patient's home. This puts me on my mettle to follow procedures exactly in line with my training and at the same time I have to be quick to make use of the resources I find there."

Many of the patients she visits are bedridden with arthritis. For instance, there is Mrs. R to whom Mrs. Walleck gives a bath, sun lamp treatment and a rubbing. As Mr. R is home on old-age assistance, Mrs. Walleck has applied a good public health nursing principle in guiding his desire to be helpful into appropriate channels. Already he has made a wooden tray on which he brings Mrs. Walleck's equipment to the sick room, and a special chair so that his wife may

sit up for part of the day. Mrs. Walleck's experience in handicrafts has also been extremely valuable in encouraging the patient to use her hands, as deformed as they are, for sewing and other handiwork.

Elizabeth Walleck is very frank about her work as a nurses' aide. Some nursing duties she finds "not exactly pleasant." In that she is no different from a professional nurse. Nor does she think it fun during a blizzard to wait on a street corner for a car to take her from one home to another. "But," she adds, "that feeling of being engaged in something worth while quickly thaws me out when I get half-frozen. All in all, my experiences have been something I wouldn't want to miss and they will always be treasured memories. Best of all, I like the fact that the public health nurses never make me feel conscious of my being merely a nurses' aide. Instead they make me feel that my work is just as important as theirs."

Public health nursing undoubtedly would have gained an extremely valuable member if circumstances had been different when Elizabeth Walleck was choosing an occupation back in the 1920's. Somebody should have guided her away from business and into the profession of nursing. As it is, public health nursing is extremely fortunate to have her now as a valued member of its indispensable army of volunteers.

THE NURSE'S AIDE IN THE VNA

THE AMERICAN RED CROSS reported that as of September 30, 1943 nurse's aides were serving in over 450 public health agencies. These agencies included both nonofficial and

*Suggestions about selecting, training and using nurse's aides to help in homes are given in the NOPHN booklet, "Volunteers and Other Auxiliary Workers in Public Health Nursing."

official. According to information from the field the number of agencies using aides had risen since then.* Even Alaska reports they are of tremendous assistance to the visiting nurses of that Department of Health in the most distant North.

In some communities where the hospitals'

(Continued on page 684)

Public Health Nurses Work with Family Agency Case Workers

By MONICA LYMAN SERGOTT

PUBLIC HEALTH organizations have expanded rapidly in the past few years. And now particularly in relation to our all-out war effort, increasing demands have been put upon public health centers and public health nurses. It has become increasingly clear with the years that there is need for the services of social case workers in relation to the new and expanding health services to assist in the diagnosis of sick and disabled persons.

Often patients are handicapped in making the best or most complete use of medical services not only by poverty, ignorance, or customs not in keeping with modern medical knowledge, but by more subtle factors of personality and emotional conditioning. Such difficulties are not confined to persons who are definitely neurotic. Perhaps the majority of people experience difficulty in adjustment to illness. Some persons more or less consciously find it so pleasant to be ill that they resist efforts to cure them. Others so reject the idea of illness that they will not cooperate toward recovery. Many others become worried and anxious about various practical aspects of illness, or have fears that may or may not be warranted by the facts. Any of these considerations may put obstacles in the way of effective use of medical facilities. Many of the obstacles can be and are being handled by physicians and nurses. Some-

times the obstacles require special knowledge of the social worker as to the other community resources. Often what is required is the case worker's special techniques of helping an individual first to discover the nature of the particular obstacles which prevent him from making effective use of health facilities and, next, to mobilize his energies and resources toward removal of the obstacles and the achievement of health.

Dr. Helen Witmer in her book titled simply, "Social Work," has defined the function of social work as an institution that serves other institutions. She points out that the family institution, for instance, is rendered more effective as a means through which basic human needs are met, when individuals who are without family ties are re-established in family groups; or, when persons who find it difficult to get along in a family group are helped to straighten out their problems. Educational and medical institutions often can carry out their functions more effectively when the special services of social work become part of a joint effort to help individuals achieve health and social usefulness. The interdependency of institutions is characteristic of the total social structure, but it is social work that has the specific task of rendering the work of other institutions more effective.

I speak from the experience of my own

PUBLIC HEALTH NURSING

agency, a district office of the Family Service Department of the Brooklyn Bureau of Charities, located in a public health center along with other related community agencies. The health center recognizes social case work as an important service for many of its patients, and the health center staff use the case workers of family service as specialists in that particular field.

The activities through which social case work of my agency has been related to public health nursing in Williamsburg-Greenpoint Health Center have been two general types: (1) consultation and guidance, with the patient as the focus of consideration but not referred for interviews with the case worker (2) referral of the patient to become a client of the family service agency while continuing as a clinic patient; or, referral when the need for clinic treatment has terminated.

Consultation and guidance is a two-way matter, constantly intermingled with the daily job in relation to persons served in common by the health center and the family agency. Consultation serves to keep open the lines of communication between the two specialized services. There are special conferences on a particular case; informal luncheon conferences at which particular types of problems encountered by both services are illustrated; and, there are more formal conferences. For example, the family service case worker is asked to attend a clinic staff conference in regard to a particular patient or several patients. Or, she is asked to attend a general staff meeting of health center nurses. In such meetings there are discussions directed toward helping the nurses to develop greater awareness of social problems, and to know the nature of services rendered by the family agency and how best to interest patients in making application for those services.

My case illustrations are those of patients known to the social hygiene clinic of the health center. That clinic has on its staff a social hygiene nurse consultant who plays an important role in patients' treatment programs. The nurse consultant often has several conferences with the case worker. This gives an opportunity to develop a common understanding between the two services, and with the patient, as to the respective roles of social and medical problems, and which service can be most helpful to the patient at a given point.

The first two cases illustrate consultation about a patient who did not become a client of the family service agency:

Case I. A young married woman was found during pregnancy to have a positive Wassermann, while her husband's was negative. The case was discussed at a social hygiene staff conference with a family agency case worker present for consultation. The patient had been treated in the social hygiene and prenatal clinics during the entire period of pregnancy and prior to the baby's birth tested negative. However, at birth the baby was found to have a positive Wassermann, and, at three weeks, treatments for the baby were begun. The mother had denied any extra-marital relationship and appeared to be very devoted to her husband. However, because of her disease she was fearful in the marital relationship and found it difficult to have normal intercourse. In time she began to fear that her husband was turning from her. No one had discussed with her the fact that she was in no danger of infecting him at that point in her treatment. Also, the necessity of treatments for the baby had filled her with fear and apprehension about the baby's future.

The young woman had discussed all these matters freely with the clinic nurse consultant with whom there was an excellent relationship. It seemed it would be artificial and difficult for her to accept another counsellor, a case worker. It was agreed at the clinic staff conference, therefore, that the medical director would see the young woman to interpret the medical aspects of the marital relationship and the clinical aspects of her illness in relation to the baby's need of treatment. If this young woman had been referred earlier the social worker

NURSING AND CASE WORK

might have been a source of direct service. But at this point, after one year of contact in the social hygiene clinic, she was so closely identified with the clinic nurse that referral elsewhere would have seemed to her only a rejection. In addition, the major problem here was a medical one and the interpretation rightly belonged with the physician.

Case II. Miss Charlotte K. a 19-year-old white girl, had become irregular in attending social hygiene clinic. She expected a baby within the month. On inquiry she told the nurse that she did not have warm clothing nor clothes in readiness for the baby. At clinic Miss K. had been consistently retiring, uncommunicative, sat by herself, displayed no emotion about herself or the baby, and had no interests outside.

Miss K. lived with a rather forbidding aunt and uncle. Her mother is a domestic on Long Island and she knows nothing of her father or his whereabouts. The putative father of her baby is in jail.

The young woman was to be brought to the family service agency personally by the nurse consultant. However, she refused to accompany the nurse further than the door, said she would make her own plans. The nurse and case worker later consulted as to how she could be helped. It was learned that when Miss K. first came to the clinic she was covered with a primary rash and several doctors had inspected her. She felt that she was on exhibition. She had resented this and was fearful of again becoming an exhibit. She was willing to return to the clinic for treatment but would not consult another agency.

It was decided the best plan would be to interest the social service department of the public hospital where Miss K. was scheduled to have her baby. With the knowledge the nurse consultant had gained, the case worker was able to prepare the hospital social service to understand Miss K. and her situation. This enabled the hospital social worker to approach her with consideration for her feelings about receiving help for herself and baby. After she has had the experience of being treated with understanding, as a person with social problems to be faced and worked out, Miss K. may be able to believe that a case worker of the family service agency is ready to help her, not to regard her as an exhibit.

The following cases are those of social hygiene clinic patients who became clients

of the family service agency on referral:

Case III. Dorothy, a 15-year-old girl, had been attending the social hygiene clinic for two years following the conviction of her 22-year-old brother for sexual relations with her which had resulted in her infection with syphilis.

She had always been a problem in the clinic and uncooperative in treatment. The family were indifferent in their attitude toward her and blamed her for the entire difficulty in which they found themselves and for the loss of the income occasioned by the jail sentence of the oldest son. The parents had never accepted the reality of the girl's forced relations with her brother.

Upon learning that her brother, following strenuous family efforts, was to be released, Dorothy came to the social hygiene clinic in hysterics. She was brought in this condition to the family service agency, following a telephone discussion of the facts.

Dorothy spoke rather freely but requested assurance that her family would in no way know of her contact with the family service agency and she would not be written to or visited at home. She was obviously nervous and upset. She is a rather large, attractive girl who appears older than her 15 years. At the time of the first interview she was sleeping in her parents' bedroom "for safety." She had never had a room of her own and formerly slept in the living room. Her three brothers shared the other bedroom. She gave an account which showed her to be a family slavey, and illustrated the complete indifference of her parents and the contempt with which they regard her. At school she was happier and had friends to whom she felt close. She had recently been admitted to a club but did not think her clothes were as good as those of the other girls and did not know how she would entertain the group, as they took turns meeting in each other's homes.

She had not done well in school and the attitude of the principal and her teachers was not sympathetic. They knew nothing of her home life.

Dorothy was unable to continue contacts with the case worker of family service because of her fear of being "found out" by her parents who had threatened what they would do to her if she brought them any more trouble. However, the interest of the school was solicited and a more sympathetic and understanding attitude created. A conference was held with the parole board and the oldest brother was not

allowed to return to or even visit the home. When this assurance was given Dorothy and she was finding satisfactions at school, she had no further need for case work service.

Case IV. Miss S. was to be married. She was 22 and her fiance was 23. When she went to a private physician for the premarital physical examination she was found to have a positive Wassermann. Her linens, her trousseau were all ready and the apartment furnished. She could not bear to tell her fiance the truth and he was told that she was anaemic, on the verge of a breakdown. She continued to visit the private physician for treatments regularly and to see her prospective husband who remained devoted to her.

However, no interpretation had been given Miss S. about her condition. She had the impression that she could *never* marry. That thought affected her relationship with her lover. The private physician was called to the Army and she came with her father to the health center for treatment. He told that she would sit for hours just looking at her trousseau and sighing. She had almost no interest in anything and was easily moved to tears. Her fiance was becoming suspicious of her behavior and questioning about her medical care. She had become frantic and recently had hysterics in the social hygiene clinic when the doctor wished to make a vaginal examination.

Miss S. was referred following a luncheon conference of nurses and case workers of family service. A case worker was subsequently asked to be present at the neurological examination and was casually included in the clinic picture following a personal introduction by the nurse consultant with whom Miss S. was very well acquainted. Miss S. made the transfer quite naturally and both she and her mother are at the present time being seen regularly at the family service agency.

She talks freely, using the case worker as an outlet for her feelings, but still has difficulty in believing that she can make definite plans for the future. Her mother is quite upset and emotional about the entire situation and contributes to the girl's confusion.

Miss S.'s behavior at the present time is a matter of grave concern to all interested in helping her. It is difficult to foretell the future, but it is apparent that under the most optimistic circumstances Miss S. has difficult times ahead of her. The family may gain a better understanding through their contacts with the social worker. And Miss S. may be helped to find

within herself the strength to see her problems through, without refuge to the mental illness toward which she appears to be headed.

The special nurse consultant of the social hygiene clinic also uses the services of the social worker where patients or relatives need help in removing environmental or financial obstacles to a treatment plan. Wherever it is possible the case worker makes every effort to have client or relatives participate in plans.

Many specific services such as arrangements for hospital care, transportation, appliances, foster home care, convalescent care, are sometimes worked out by the nurse in collaboration with a social worker. Some of these things are carried through directly by the nurse consultant herself.

If the patient is without material resources, or without knowledge of available facilities for carrying out his plans, the family agency case worker can make this information available and can meet the financial need if it is part of the total treatment plan. If the patient is unable because of fear, anxiety or confused feeling to accept his situation for what it really is, the social worker may help by encouraging expression of his pent up feeling, thus releasing tension. Then, too, with the help of the case worker, patients can sometimes recognize that their unhappy reactions or difficult behavior represent their characteristic ways of meeting difficulty. With that clarified and help in examining both the actual limitations facing him as well as the forces which may be brought to his aid, the patient is better able to take necessary steps toward a solution of his problems. The social worker often finds that patients are uncertain as to the implications of their illness, or unclear as to why treatment is necessary, its possible and probable results. In such instances the social worker reports back to the clinic where the

only satisfying and authoritative explanation can be given the patient.

We find, then, that there is both need and opportunity for a two-way educational process—the public health nurse and the family agency case worker sharing their knowledge and pooling their efforts to promote health and well-being. The social work staff makes a particular effort to report back regularly on all active cases and to explain fully reasons for acceptance or rejection of a case. There is also a review of the case situation when the family service worker plans to close, so that progress and reasons for closing may be fully understood by the health center staff.

A system of referral is being experimented with in the social hygiene clinic of the Williamsburg-Greenpoint Health Center. The social hygiene nurse consultant tells the patient that there is a "specialist" who she feels could be helpful with her problem and requests a social worker to come to meet the patient in the clinic. The patient immediately identifies the social worker with the clinic, recognizes her as someone in whom the clinic has confidence and with whom intimate knowledge may be shared safely. The burden for interpretation of the social agency's function then rests with the social worker. It was found that referrals to an unknown and little understood agency were very difficult to complete with patients having guilt and anxiety about the entire matter of coming to a social hygiene clinic. The patient is left quite free to choose whether she wishes case work service or not. The element of choice eliminates the authoritative or threatening aspect of the public health official who has police power, and minimizes the patient's resistance to accepting case work help.

We realize, of course, that such a procedure might not prove practical outside of a setting where clinic and agency are under the same roof.

The development of a close working relationship between health center nurses and family service agency case workers as I have experienced it, has led to a joint increase of knowledge and understanding. Social workers have a better attitude toward venereal disease, regard it as just another communicable disease to be treated. They are more alive to the various manifestations which indicate a need for medical care, and to the existing resources or, equally important, the lack of resources for meeting health needs. Nurses have a better awareness of the social implications of disease and the ways by which the social worker tries to meet the individual's needs.

Keeping the channels of communication open by informal conferences and planned case consultations has made for a give and take which facilitates the co-operative work in the interest of the individual. The nurse knows and believes that the social worker is eager and willing to be of service and that she is trying to be as available as possible. On the other hand, the social worker recognizes that the nurse is equally eager to serve the client efficiently and well. This breaking down of barriers which have somehow arisen between case workers and nurses is the only way by which the individual client or patient can be effectively helped. The restoration of individuals to a condition of health and social usefulness is an important means of furthering national strength in wartime.

From a paper read at the 11th Regional Conference on Social Hygiene, Hotel Astor, New York, N. Y., February 3, 1943.

PUBLIC HEALTH NURSING

The Nurse's Aide in the VNA

(Continued from page 678)

need for nurse's aides has not been filled, aides are not available to public health agencies. Even so, the directors of the Volunteer Nurse's Aide Corps at Washington are well satisfied that some aides in many places are receiving public health experience in order to become better acquainted with community health problems outside the hospitals.

Since the inauguration of the nurse's aide program, 97,000 women have received nurse's aide certificates under 2,000 professional nurse teachers, and the majority of them are now in

active service in hospitals and other health agencies throughout the country. To them the American Red Cross pays this tribute:

"The load which they are taking from the shoulders of the professional nurses can never really be measured, but their value is becoming increasingly apparent as professional and non-professional groups learn to depend on each other and to work together more effectively. The appreciative comments about the work of the volunteer nurse's aides, coming from hospitals and organizations where they are serving, are not only a tribute to the spirit and sincerity of the aides themselves, but to the nurses who have been their instructors and have put the stamp of quality upon them."

NURSE PLACEMENT SERVICE

NPS announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom consent to publish these has been secured in each case from both nurse and employer.

PLACEMENTS

- *Ruby Burkart, nursing field consultant, American Red Cross, Midwestern Area, St. Louis, Mo.
- *Evelyn Rhodes, information secretary, Bronx Tuberculosis and Health Committee, Bronx, N.Y.
- *Anna Burkhardt, generalized supervisor, Instructive Visiting Nurse Society, Washington, D.C.
- Helen Donovan, educational supervisor, Visiting Nurse League, Fort Wayne, Ind.
- *Edith Adams, school nurse, Maine Township High School, Park Ridge, Ill.
- Helen Carlson, tuberculosis public health nurse, Community Clinics, Incorporated, Pueblo, Colo.

- Mrs. Margaret Boyd, industrial nurse, Teletype Corporation, Chicago, Ill.
- Mrs. Gertrude Trautwein, industrial nurse, Binks Manufacturing Company, Chicago, Ill.
- Mrs. Rose White, industrial nurse (nights), Grand Sheet Metal Works, Chicago, Ill.
- Mrs. Edna O'Connor, industrial nurse, Central Pattern and Foundry Company, Chicago, Ill.

ASSISTED PLACEMENTS

- *Ruth Burcham, executive director, Visiting Nurse Association of San Francisco, San Francisco, Calif.
- *Christine Wright, nursing consultant, American Red Cross, Eastern Area, Alexandria, Va.
- *Mrs. Ruth Smith, supervising nurse, LaSalle County, Illinois State Department of Health, Springfield, Ill.
- *Ann Richardson, supervisor, Waterbury Visiting Nurse Association, Waterbury, Conn.
- *Henrietta Perlman, staff nurse, Community Service Society, New York, N.Y.
- *Mrs. Lillian Monks, school nurse, San Diego City Schools, San Diego, Calif.

*The NOPHN files show that this nurse is a 1943 member.

Reviews and Book Notes

HOME CARE OF TUBERCULOSIS

Four pamphlets under this general title—A Guide for the Family (25c), Pointers for Nurses (15c), Hints for the Patient (5c), all by Dorothy Deming and The Family Physician in Charge (10c) by the National Tuberculosis Association. Available through local or state tuberculosis associations.

These four manuals will be most valuable aids in the work of caring for the tuberculous patient at home. They are written in an easy, informative style and are very practical, with consideration and appreciation of the manifold problems involved. The format and the arrangement of the pamphlets makes them easy to follow. Questions and answers at the end of two of them are pertinent and well chosen.

The scientific and technical content is safeguarded by the fact that three advisory committees, of doctors, of nurses and of state tuberculosis secretaries assisted at every stage of their preparation.

With the knowledge of dietary needs so authoritatively recognized today, diet seems particularly pertinent to emphasize and it could have been more specifically developed. Experience has shown that few patients, even well-to-do ones, know what constitutes a well selected diet and need help. The bibliographies, so complete as far as the disease itself is concerned, might have included some specific references on foods.

The rest of mind of the patient is well stressed. Financial security, however, often the patient's most worrisome problem, was mentioned only in the nurse's pamphlet. The fact that most communities are prepared to meet the patient's financial needs during crises could well

have been included in the other manuals.

Needful emphasis was made of the patient's own responsibility in regard to kissing and the protection of others; but the problem of sexual relations was raised only once, under "questions and answers" in "A Guide For The Family." Rightly it was referred to the physician. However a real opportunity was missed to encourage patient, family and nurse to discuss more openly and realistically this serious and often evaded problem.

The manuals are so excellent that they should become working tools for every nurse concerned with the care of tuberculous patients.

BEATRICE HEATON, R.N.
New York, N. Y.

BEHIND THE SULFA DRUGS

By Iago Galdston, M.D. 170 pp. D. Appleton-Century Company, New York, 1943. \$2.

Soldiers going into combat today carry "charmed bullets which strike only those objects for whose destruction they have been produced;" not in a cartridge belt for a tommy gun, nor in a sheath for hand to hand fighting but in a small sealed paper envelope. Inside this is a smaller envelope containing a crystalline powder which, by means of a clever shaker device, can be sprinkled like salt upon injured flesh. This destroys, or renders effectively harmless, the invidious enemies that produce disease. It is one of a group of sulfonamide compounds which have revolutionized the practice of medicine in the last decade.

The dramatic story of the discovery of the sulfa drugs is told with a deep sense of appreciation for the courageous men

PUBLIC HEALTH NURSING

whose arduous years of toil, with alternating periods of frustration and inspiration, finally culminate in the achievement of modern chemotherapy. The events leading up to the discovery cover a period of four hundred years. Entrepreneurs, chemists, physicists, biologists, bacteriologists and physicians, pass in review with just enough of anecdotal interest concerning their personalities and accomplishments to whet the reader's appetite.

The publication of this book is timely and its size and inimitably facile style, in spite of a generous interlarding of scientific explanations, will do much to popularize it. Public health nurses are advised to take this as a nightcap after which they will list it as one of the "musts" for their reference libraries.

MIRIAM AMES, R.N.

Baltimore, Md.

RECENT PUBLICATIONS AND CURRENT PERIODICALS

GENERAL

THE CASE WORKER AND FAMILY PLANNING. Planned Parenthood Federation of America, Inc. 501 Madison Ave., New York City. 1943. 10 cents.

SCHOOLS AWAKE. A Cooperative Community Program in Van Buren County, Michigan. Distributed by W. K. Kellogg Foundation, Battle Creek, Michigan.

The story of a cooperative community enterprise in which the citizens of Van Buren County, Michigan move toward a solution of their school problems.

RURAL FAMILY SPENDING AND SAVING IN WARTIME. U. S. Department of Agriculture, Misc. Pub. No. 520. June 1943. 163 pp. 20 cents.

Published as a part of the study of family spending and saving in wartime, conducted by the Bureau of Human Nutrition and Home Economics, Agricultural Research Administration in cooperation with the U. S. Bureau of Labor Statistics.

HARD OF HEARING

REHABILITATION AND PLACEMENT OF THE DISABLED. Arranged by Dr. H. V. Morkovin,

Chairman, Pacific Zone of the American Society for the Hard of Hearing. Available from Mrs. Mary Rogers Miller, 1209 Crenshaw Blvd., Los Angeles, 1943. 29 pp. 50 cents.

HEALTH

DENTAL HEALTH. Bureau of Dental Health, New Jersey State Department of Health, Trenton, New Jersey.

This is an excellent source of scientifically sound information on dental health, in addition to the valuable suggestions concerning school dental programs including criteria for evaluation, outstanding in the material on teaching dental health; community standards for dental care and bibliography.

THE CHILD

SUPERVISED HOMEMAKER SERVICE (A Method of Child Care). Publication 296, U. S. Department of Labor, Children's Bureau, Washington, D.C. 1943. 36 pp. 10 cents.

TREND OF CHILD LABOR 1939 to 1942. *Monthly Labor Review*, March 1943. U.S. Department of Labor, Bureau of Labor Statistics, Washington, D.C. 1943. 20 pp. Free.

THE AMERICAN JOURNAL OF NURSING FOR DECEMBER

Penicillin, Chester S. Keefer, M.D.

Rheumatic Fever and the Nurse, Edith M. Terry

Mental Hygiene and the Nurse, Katherine Brownell Oettinger

Acute Bacillary Dysentery, Charley J. Smyth, M.D., and Ann Kaiser, R.N.

Nursing in Tuberculosis Hospitals, Dorothy Deming, R.N.

Nursing Care of the Aged, Sarah B. Gelbach, R.N.

NOTES FROM THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

BOARDS WILL MEET

The annual meetings of the Board of Directors of NOPHN and of the joint boards of the three national nursing organizations will take place on January 28 and January 29 respectively.

IN THE FIELD

INDUSTRIAL NURSING SECTION, CONNECTICUT STATE NURSES' ASSOCIATION, October 25-November 17—Heide L. Henriksen was special lecturer at a series of institutes held by the SNA in Bridgeport, New Haven, and Hartford. . . . INFORMATIONAL CONFERENCE ON THE RELIEF AND REHABILITATION PROGRAM OF THE UNITED NATIONS, Washington, D. C., October 29 and 30—Mrs. Edith Wensley attended this conference as the NOPHN representative. . . . SECOND WARTIME PUBLIC HEALTH CONFERENCE, Grand Rapids, Michigan, November 3, 4 and 5—Hortense Hilbert spoke at the public health nursing session the afternoon of the fourth. . . . SIMMONS COLLEGE, Boston, Massachusetts, November 4—Miss Henriksen addressed an evening class of industrial nurses. . . . FORTY-THIRD ANNUAL CONVENTION OF THE GRADUATE NURSES' ASSOCIATION OF VIRGINIA, Roanoke, November 9, 10, and 11—Miss Hilbert participated in the session "Overview of Nursing" on November 9, speaking from the public health nursing point of view. . . . THE WESTCHESTER NURSING COUNCIL, INC., White Plains, N. Y., November 17—Miss Hilbert met with representatives of six public health nursing associations of Westchester County to discuss extending nursing care of the sick in their homes to those insured in a group hospital plan. . . . VISITING NURSE ASSOCIATION OF STATEN ISLAND, INC., Staten Island, N. Y., November 29—Margaret S. Arey gave this organization a day's advisory service regarding the orthopedic aspects of their program. . . . PROCUREMENT AND ASSIGNMENT SERVICE, Washington, D. C., No-

vember 30—Ruth Houlton attended a meeting of the Advisory Committee on Public Health.

REVISED BIBLIOGRAPHIES READY

The arduous and painstaking process of bringing the bibliographies up to date is under way, and in this, NOPHN is grateful for the help of Mrs. Austin J. Smith of Cleveland, better known to Magazine readers as Purcelle Peck, former editor. Mrs. Smith has completed new bibliographies on administration, maternity, premature infant, and mental hygiene and these are available upon order, at 10 cents a copy. A very extensive new list on publicity methods and techniques prepared by Edith Wensley is also available.

HONOR ROLL

ALABAMA

Center—Cherokee County Health Department

*Dadeville—Tallapoosa County Health Department

ARIZONA

Phoenix—Union High Schools

ARKANSAS

Little Rock—Visiting Nurse Association of Greater Little Rock

Morrilton—Conway County Health Department

CALIFORNIA

*Los Angeles—Metropolitan Life Insurance Nursing Service

CONNECTICUT

*Essex—Public Health Association

*Meriden—Public Health and Visiting Nurse Association

Middlebury—Board of Education

FLORIDA

Chipley—Washington County Health Department

Fernandina—Nassau County Health Department

*Agencies which have been on the Honor Roll for five years or more.

PUBLIC HEALTH NURSING

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Dawson—Cotton Oil Company

ILLINOIS

Cairo—Metropolitan Life Insurance Nursing Service

*Maywood—Board of Education, District No. 89

IOWA

Albia—Monroe County Nursing Service

*Onawa—Monona County Nursing Service

MAINE

Farmington—Department of Health and Welfare District Health Center II

MICHIGAN

Allegan—County Health Department

Grand Rapids—Board of Directors—Community Health Service

MINNESOTA

Anoka—County Nursing Service

Bemidji—Beltrami County Nursing Service

Cambridge—Isanti County Nursing Service

*Cass Lake—Chippewa Indian Health Unit

Duluth—St. Louis County Nursing Service

Faribault—Visiting Nurse and Service Association

Grand Marais—Cook County Nursing Service

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Red Lake—Beltrami County Indian Service

Red Wing—Metropolitan Life Insurance Nursing Service

Virginia—School Nursing Service

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Springfield—Greene County Health Department

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Helena—Montana State Board of Health

Lewistown—City-County Department of Health

NEVADA

*Reno—Nevada State Department of Health

NEW JERSEY

*Westfield—District Nursing Association

NEW YORK

*Albany—Visiting Nurse Association

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*New York—Community Service Society

Oneonta—Visiting Nurse Association

*Rochester—Visiting Nurse Association

*Tonawanda—Metropolitan Life Insurance Nursing Service

NORTH CAROLINA

Concord—Metropolitan Life Insurance Nursing Service

NORTH DAKOTA

*Fargo—Nursing Bureau of Fargo Health Department

OKLAHOMA

Watonga—Blaine County Nursing Service

Wewoka—Seminole County Health Department

PENNSYLVANIA

Lewistown—Public Health Nursing-Public Schools

*Philadelphia—Negro Bureau of Philadelphia Tuberculosis & Health Association

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Chester—County Health Department

TENNESSEE

Cleveland—Bradley County Health Department

Clinton—Anderson County Health Department

Dayton—Rhea County Health Department

Jonesboro—Washington County Health Department

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Mountain City—Johnson County Health Department

Pikeville—Bledsoe County Health Department

*Ripley—Lauderdale County Health Department

VERMONT

Waterbury—Public Health Association

VIRGINIA

Berryville—Clarke County Public Health Association

WYOMING

Cody—Park County Nursing Service

Kemmerer—Lincoln County Nursing Service

Rock Springs—Sweetwater County Nursing Service

Sheridan—County Nursing Service

Wheatland—Platte County Nursing Service

Worland—Washakie County Nursing Service

NEWS

Highlights on Wartime Nursing

NATIONAL NURSE MOBILIZATION

The week of February 7 to 12, 1944 is set by the War Manpower Commission, Procurement and Assignment Service, for nationwide registration of nurses. This will take the place of the annual inventory conducted by the U. S. Public Health Service in 1941 and 1942.

Available figures on the total number of registered graduate nurses fall way below the truth. The 1944 registration is counted upon to provide the comprehensive picture of nurse-power now urgently needed as a basis for national planning. As further information about mobilization procedures is available it will be quickly transmitted to the nursing profession. In the meantime nurses everywhere are urged to put the dates on their calendars, tell others about it, make renewed efforts to persuade retired or inactive nurses to come forward for whole or part-time service.

The mobilization registration will be entirely voluntary. No coercion, as some nurses wrongly believe, can or will be placed upon any individual nurse to serve any place other than she herself decides. Registering or not registering will not affect her professional status. While efforts may be made by local procurement and assignment committees to persuade her to serve in what they believe to be an area of greater need, there is no government power at present which can require her to do so. However, it is her professional and patriotic duty to register. Only by a 100 percent registration can the necessary information be procured to plan adequately for the nursing needs of the armed forces, the great civilian protective services, and to gauge how far the available supply of nurses must be supplemented by recruitment and training of student nurses, and auxiliary workers.

NURSING COUNCIL

- One hundred and forty-six colleges in 35 states were visited by 18 members of the College Field staff during the first month of the college visitation and counseling program which began October 1 under joint auspices of the U. S. Cadet Nurse Corps and the National Nursing Council for War Service. Eleven thousand students have been reached in the audiences addressed by the staff who have also conducted approximately 600 personal interviews. Visits to 350 additional colleges are being scheduled for November and December and 100 more for early 1944.

- During the month of October, 45,199 inquiries from young women interested in becoming nurses were received by the Clearing Bureau of the National Nursing Council for War Service which operates also for the U. S. Cadet Nurse Corps. This is the largest total for any month in the history of the Bureau.

- A history of nursing in World War II will be prepared by the National Nursing Council for War Service. This project was originally undertaken by the Subcommittee on Nursing of the Office of Community War Services (formerly the Office of Defense Health and Welfare Service) at the request of the National Research Council. As the functions of the Subcommittee have changed and it no longer maintains a staff, the Councils Board has approved its request that the Council take over the project. Alma C. Haupt was appointed chairman of the Council committee to be set up to guide the project.

- Louise Kieninger who for the past 16 months has been in Brazil assisting in the organization

of the Civilian Defense program and serving as consultant on nursing and hospital problems and Red Cross nurses' courses, has rejoined the staff of the National Nursing Council for War Service as assistant executive.

• Lucy D. Germain, field representative of the *American Journal of Nursing*, is preparing for the council up-to-date charts on its organization and functions and its relation to other governmental and voluntary nursing organizations.

HOSPITALITY FOR ARMY AND NAVY NURSES

With Christmas and New Year's a matter of days away, public health nurses everywhere will be particularly interested in the Nursing Council's recent letter to state and local nursing councils urging them to promote hospitality and friendly courtesies for the Army and Navy Nurse Corps members. Public health nurses also, both individually and in groups, will wish to follow up the several excellent suggestions, especially those relating to nurses in nearby camps or other military establishments. Many public health nurses will, in fact, be in a position to entertain corps nurses in their own homes. For nurses in foreign service the letter suggested that local nursing councils might encourage alumnae groups to: (1) remember anniversaries (2) send messages after annual school meetings to members in the armed service (3) send professional magazines (4) send mimeographed letters to all members in the Army and Navy Nurse Corps at regular intervals.

For Army and Navy nurses in this country it is suggested that state and local councils: (1) extend invitations to nurses in their vicinity to attend meetings and social events of nursing organizations (2) ask permission to hold occasional nursing association meetings in Army camps and Navy stations (3) enlist the help of the American Red Cross Motor Corps in providing transportation to such meetings (4) stimulate local interest in establishing recreational huts for nurses (5) arrange with local clubs (nursing or other) for temporary membership and use of their facilities by members of the Army and Navy Nurse Corps.

The superintendents of both the Army and Navy Nurse Corps have endorsed these suggestions, pointing out that in plans for the entertainment of service people nurses are usually forgotten.

WLB RULING AFFECTS VNA'S

Non-profit organizations which have been exempted from the payment of income and social security taxes do not have to file applications for approval of wage and salary adjustments with the National War Labor Board, according to a WLB ruling released recently.

The Board's resolution, covering non-profit charitable, scientific, literary, religious or educational organizations, stated that such organizations will be expected to observe and abide by the national wage and salary stabilization policy in making any wage increases.

HOME NURSES AS VOLUNTEERS

To help meet the demand for more volunteers in hospitals, VNA's, day nurseries and other health organizations by utilizing the services of women who have completed the Red Cross Home Nursing course, and at the same time to safeguard both the persons receiving care and the workers giving it, a statement of policy has recently been formulated by directors of both volunteer and nursing services:

"Home nurses who can give the required time should be trained for membership in one of the Red Cross Volunteer Special Services—nurse's aides, hospital and recreation workers (Gray Ladies), dietitian's aides and staff assistants—but where these services are non-existent or cannot be organized, or where it is found that the membership in these corps cannot be increased sufficiently to meet the community needs, the Red Cross chapters may, upon request, make available to hospitals or other community agencies the names of those women who have completed the home nursing course.

"Names of home nurses should be released only on two conditions: that the women have given permission for their names to be released, and that the selection of the volunteer workers, their additional instruction and the supervision of their work be the responsibility of the organization using their services and not

the responsibility of the American Red Cross.

"Selection of the individual volunteer workers should be based on reliability, efficiency and aptitude, and additional instruction and supervision should be given by a professionally trained person."

PEDIATRIC AFFILIATIONS CONFERENCE

Under the auspices of the U. S. Public Health Service a conference of specialists in the medical, psychological and social phases of child care was held in Washington, D. C. on November 4 to examine existing pediatric instructional facilities and to explore methods of increasing pediatric affiliations. The meeting, presided over by Surgeon General Thomas Parran and Lucile Petry, director of the Division of Nurse Education, was attended also by representatives of the Advisory Committee to the Division and the U. S. Cadet Nurse Corps program.

Possibilities for the expansion of instructional facilities and for remedying the critical shortage of nurses were reviewed, and three committees were appointed.

The first is to report on the availability of pediatric facilities and to suggest a plan of procedure for studying community facilities. This plan will be transmitted to cooperating groups for more specific developments. Dr. Martha Elliot, associate chief of the Children's Bureau, is chairman of the committee. The second committee, with Marion G. Howell as chairman, will report on recruitment technique for postgraduate courses. The purpose of the third group is to urge committees of national nursing organizations to plan streamlined courses to prepare instructors.

It was voted at the meeting to ask the U. S. Public Health Service to make a sample survey of community facilities to illustrate how child care facilities can be located and organized for integration into programs of nursing schools.

COUNCIL OF FEDERAL NURSING SERVICES

A Council of Federal Nursing Services has been established recently in Washington with the following objectives: (1) to provide a means of easy exchange of information about

federal nursing services (2) to provide mutual assistance in the consideration of the nursing problems presented by the federal agency nursing services and (3) to formulate recommendations concerning federal agency nursing problems for which consideration by the National Nursing Council for War Service is desired. Membership of the Council is made up of the directors of nursing in the various federal agencies. A representative of the American Red Cross Nursing Service and the National Nursing Council for War Service serve as liaison members. The Council will meet monthly in Washington.

- Due to the urgency of the war situation, which requires the recruiting of 2,500 nurses each month for service with the Army and Navy, the Red Cross Nursing Service will, on January 1, 1944, discontinue the enrollment of nurses 45 years of age and over and of those otherwise not eligible for services with the armed forces. For many years the Red Cross Nursing Service has maintained a Second Reserve, in addition to its War and First Reserves. Nurses who at the time of application did not meet the requirements of the Army or Navy Nurse Corps because of age, physical condition, or other reason were enrolled directly; those who became ineligible for military service subsequent to enrollment were transferred into the Second Reserve.

- The appointment of Mrs. Estelle Massey Riddle, well-known Negro nurse educator, to the Advisory Committee of the Division of Nurse Education, has been announced. Mrs. Riddle is consultant and resource executive in relation to Negro nursing and the war effort on the staff of the NNCWS.

- Rita Miller has been appointed consultant on Negro nurse education in the Division of Nurse Education, U. S. Public Health Service, it is announced by Lucile Petry, director of the Division. Miss Miller is on loan from Dillard University, New Orleans, where she is chairman of the Division of Nursing.

In connection with her work for the U. S. Cadet Nurse Corps, Miss Miller will assist Negro schools in applying for participation in

PUBLIC HEALTH NURSING

the program. She will be charged with helping the schools to qualify for the Corps and, in general, to facilitate the inclusion of more Negro students in the program.

Great gains for the Negro nursing program

should be realized through Miss Müller's work, Miss Petry says. "There are broad opportunities for advancement in Negro nursing. The Division's new consultant will explore every such possibility."

From Far and Near

• Leah M. Blaisdell, acting director of the Henry Street Visiting Nurse Service, will speak on "The Role of the Nurse" over station WNYC, December 17 at 11:45 a.m. On December 23, same station, at 1:15 p.m. Bosse B. Randle will talk about "Adventures in Controlling Tuberculosis." Miss Randle is chairman of the Nursing and Social Service Section, Tuberculosis Sanatorium Conference of Metropolitan New York, also secretary of the NOPHN School Nursing Section. These are two in the New York Tuberculosis and Health Association series of Christmas Seal radio programs in November and December.

• The Frontier Nursing Service is soliciting gifts of toys and dolls, new and old, for girls, big boys and tiny tads; also clothing, new and old; woollies for babies; and candy. Send by parcel post to Hyden, Kentucky, or by freight or express to Hazard, Kentucky.

• Mary E. G. Bliss will go to Boston early in December as registrar of the Central Directory for Nurses of District 5, Massachusetts State Nurses Association, succeeding the late Marietta D. Barnaby. For seven years Miss Bliss has been a member of the staff of the American Nurses' Association.

• The resignation of Mary D. Davis, for 15 years director of public health nursing for the New Hampshire Department of Health, became effective November 1. Mrs. Davis has accepted a new assignment with the Department as research consultant. Her first activities will be concerned with a study of clinic record keeping with special reference to venereal disease control. Recommendations for improved follow-up work in the larger clinics are expected to result from the study. Another important aspect of her work will be the formulation of an educational program concentrated upon youth and certain problems arising from juvenile delinquency.

Florence M. Clark has been appointed by the State Board of Health as acting director of public health nursing.

Community Health Service—An experiment in improving the education for healthful living of 999 senior girls in 26 Michigan high schools during the year 1942-43 is described in the bulletin, "Leads to Better Community Health." This is a project of the State Board of Education of Michigan, promoted by the State Departments of Public Instruction and Health and financed by the W. K. Kellogg Foundation. The success of the experiment led to numerous requests by other secondary schools for organizing such a course and in the 1943-44 school year 200 schools will offer the Community Health Service course and more than 5,000 girls will participate. Statewise, a qualified public health nurse, Mrs. Genevieve R. Soller, has served as director and coordinator. Locally a classroom teacher plus a nurse consultant conduct the study and field work, assisted by a variety of resource persons in the school and community invited to assist in the development of various aspects. A syllabus suggesting areas of study planned as units was provided each school. The content of the course was flexible but inclusive, planned to meet the needs of the average high school girl. The use of the syllabus was intended to serve as a guide to later revision and improvement in the light of experience. As revised the units were: (1) analysis of local health agencies (2) analysis of individual health status (3) family health (4) health agencies, community health and the school health program (5) nursing skills (6) health progressions. A single copy of the syllabus is available from the Michigan Department of Public Instruction, Lansing, Michigan, at 75 cents.

Rehabilitation of Disabled Soldiers and Sailors—A recent Office of War Information report passes along suggestions by the Surgeon

NEWS NOTES

General of the Army concerning everyday behavior on the part of friends, family and acquaintances most calculated to lessen the inevitable difficulties of adjustment of disfigured and disabled veterans. "Thanks to modern therapy many of the men suffering from even the severest wounds will be rehabilitated and enabled to lead lives of normal activity, engaging in industry, business or professions. But the most modern medical and psychiatric care, the finest surgery and appliances, expert rehabilitation, vocational training and employment opportunities are far from being all that is needed by the men who have suffered disfigurements and disabilities. Much of the work can be undone or will remain incomplete if the men's families and friends and the public at large fail to behave with restraint, intelligence and consideration."

The patient himself may have a wrong conception of what disability may mean to him. A boy who has lost both legs may see himself as a beggar on the street; a man newly blinded, as selling pencils or shoelaces on a crowded thoroughfare. By such thinking, fed by ignorance of the important work disabled men are doing in industry and business, self-confidence is lost and bitterness grows. Such emotional reactions have been anticipated and plans for rehabilitation by experts in physical and mental health have been carefully laid and are being carried out now by the various agencies concerned in the restoration of injured boys to health.

The first and perhaps most important step is the restoration of self-confidence. This begins in the hospital as soon as possible after injury. Among other methods used, is that of having individuals with similar injuries come into the hospitals and demonstrate their restored usefulness and return of function to the patients who are not told at first of the visitors' disabilities. When the boy learns the true state of affairs, it has an important psychological effect on him and is worth more than a thousand words of reassurance by one of the workers.

Second is physical rehabilitation. Injured muscles are restored to usefulness. Patients are given carefully fitted appliances to take the place of amputated limbs. Nervous disabilities are given careful attention.

As a third step, when the patient has recovered physically and mentally and is discharged from the hospital, vocational training is begun. Vocational training is "useful, functional independent living—not dependent, permanent residence in hospitals." At government expense the man will be taught the skills of a job.

Finally the patient is then ready for employment. Many agencies are working for wounded servicemen: Army, Navy, Civil Service Commission, United States Employment Service, Office of Education, Red Cross. All have plans to insure the employment of discharged service men, including the disabled. Great care is taken to see that the boys are properly placed.

But the most modern medical and psychiatric care, the finest surgical care and appliances, expert rehabilitation, vocational training and employment are not enough.

"The families, friends, and acquaintances of the disabled and disfigured men, and the public at large have a responsibility in the matter too. It is up to them to further the men's progress during rehabilitation by considerate and co-operative behavior. Men who are working hard to acquire new self-confidence, or who have acquired it, must not be jolted out of it by thoughtless, uncontrolled manifestations of pity or horror or distaste or false cheeriness or too-eager curiosity, or other emotionalism."

A list of suggestions for families and friends and all others who come in contact with wounded men is given. These guideposts apply to all types of disability cases and are not only for the hospitalization period but also for the time when the patient returns to civilian life. They are:

1. Treat the maimed person as the normal person he always has been and continues to be.
2. Don't ask questions or give advice.
3. Be casual and realistic—not over-cheery.
4. Don't wait on the injured man too much.

Therefore, the job that lies ahead in the restoration to usefulness of disabled servicemen includes the workers in the hospitals, the division of rehabilitation and employment, the patient's friends, his family, and the patient himself. The part which the family can and must play in the total rehabilitation of the disabled service man cannot be underestimated.

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